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Cover This week's Pharmacy Champion Kate Forsey Picture: Charlie

# RPSGB stands defiant in face of Foster regulation proposals

**RPSGB** Not enough evidence to implement report recommendations, says Society

Ailsa Colquhoun

**The RPSGB has called for a greater** evidence base and more properly thought-out proposals in a somewhat defensive response to the Foster report on the regulation of non-medical healthcare professionals.

Tackling the question of the dual functionality of the Society, RPSGB president Hemant Patel stressed that there is "no evidence" that the non-medical regulators have been slow to identify or deal with serious failings, nor that they have slowed down the pace of change in respect of professional or service development.

He said: "In fact the RPSGB has a proven track record of adapting to continuing changes in society."

Citing the establishment of the national boards, the RPSGB points out that it is already working on a constructive solution to clarifying its dual regulatory and professional functions, and said there needs to be a great deal more discussion to find a solution that also allows the Society to support pharmacists in practice.

"The RPSGB has been proactive in reviewing and developing its role as the regulator of the profession in order for it to remain fit for purpose in serving the public interest," Mr Patel said.

Looking at the wider aim of the report, which was published to supplement the chief medical officer's 'Good doctors, safer patients' report on the regulation of medical professionals, Mr Patel welcomed the idea of achieving one integrated and consistent framework of regulation.

However, he accuses the two report authors of treating doctors differently to other healthcare professionals.

"We see medical exceptionalism as likely to hinder rather than promote improvements in the quality and safety of healthcare."

The RPSGB's response also warns of the risk of increasing the regulatory burden if changes are not properly thought through and costed prior to implementation.

How should you be regulated? The industry speaks on page 10

## To merge or not to merge?

Royal Pharmaceutical Society of Great Britain

**RPSGB** says it recognises the logic of consistency in regulating the pharmacy profession at the UK level. However, it also believes that PSNI views are paramount, and that if plans for a potential merger are taken forward, a joint approach to initial assessment and implementation plans is vital.

**PSNI** has rejected the proposal. In its response it says: "We already have a Society with statutory functions defined, we have a structure in place, which is clearly enshrined in legislation and we are working to define the costs and the timelines to enable the changes, enabling a reformed and fit for purpose regulatory function. This does not require a root and branch reform." See www.dotpharmacy.com for full response.

# Pfizer attempts to address industry concerns

**Industry** Details of distribution plan sent to UK pharmacies

Tom Hawkins

**Pfizer has contacted pharmacies in** the UK to address industry concerns over its proposed sole distribution scheme with UniChem.

From Thursday, pharmacies in the UK began receiving a three-page 'Q&A' letter in which the drug giant gave an update on implementation of the plan. The document, written by head of trade David Watson, explains the rationale behind the move and reiterates the partners' guarantee for 100 per cent coverage by March 2007.

On stock availability concerns, Pfizer said it will increase the quantities of prescription drugs held in reserve in the UK. Details of discount arrangements will be released within a fortnight following talks with trade bodies.

Within the next few weeks all pharmacies will have a sign-up pack. It will contain questions on the ordering system in use to establish whether IT changes are necessary. Orders can also be placed by phone and fax.

Pfizer's letter comes a week after Numark contacted its members, urging them to raise specific concerns over the deal.

Director of professional services Mimi Lau said: "For our members it could mean a different way of working and they need to know how they are going to plan for it."

Pfizer's David Watson has written to UK pharmacies

# Scottish pharmacy leaders take stand against Pfizer

Pharmacy leaders in Scotland have decided to take a stand against the distribution deal announced by Pfizer.

The move came after the standing committee of the Scottish Pharmaceutical General Council met individually with representatives from Pfizer, UniChem, AAH, Phoenix and Rowlands in early November.

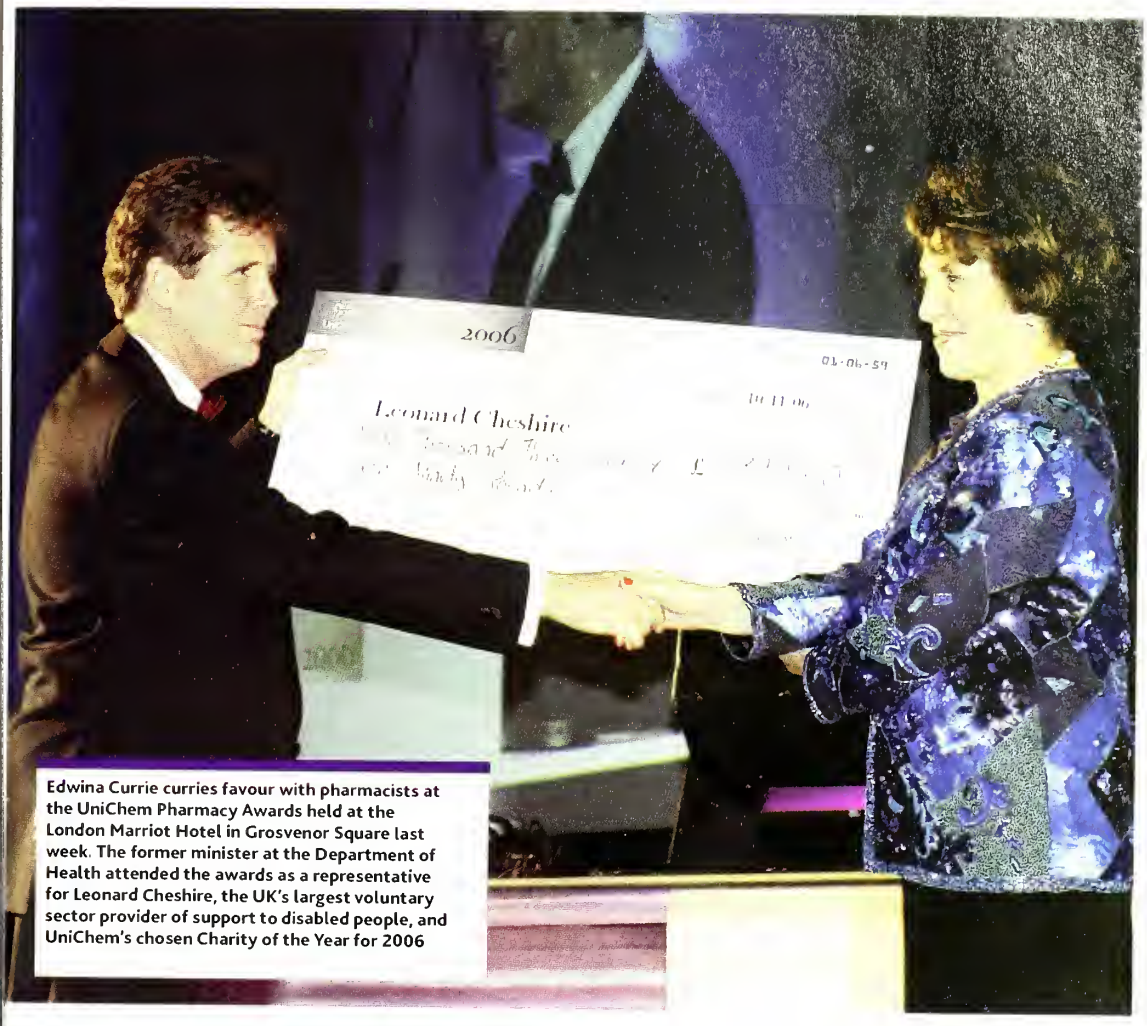
The Council said it understood both sides of the argument but felt the problem of counterfeit medicines would be better dealt with by wholesalers and drug manufacturers working together to further packaging technology, such as RFID tagging.

Alex MacKinnon, head of parliamentary and corporate affairs, said: "This injects quite a high level of risk into a system that works very well."

Pfizer, however, maintained that the only way to prevent counterfeits reaching patients was to offer "a secure channel direct from manufacturer to dispenser".

The SPGC urged pharmacists and patients in Scotland to contact their local MSP with their fears. It has also outlined its concerns to the OFT.

• The Dispensing Doctors' Association has joined the list of pharmacy groups that have sent a letter to the OFT expressing concern at the impact of proposed changes to the distribution of Pfizer medicines.




Edwina Currie curries favour with pharmacists at the UniChem Pharmacy Awards held at the London Marriot Hotel in Grosvenor Square last week. The former minister at the Department of Health attended the awards as a representative for Leonard Cheshire, the UK's largest voluntary sector provider of support to disabled people, and UniChem's chosen Charity of the Year for 2006

# Government urged to own up over control of entry 'error'

## Legal Industry figures dismiss DH reasons for rewording of NHS bill

**Max Gosney**

**Pharmacy stakeholders have** accused the Department of Health of fouling up a control of entry rules change.

Industry sources rubbished DH claims that rewording the "necessary or desirable" test to "necessary or expedient" would not change the criteria for contract applications.

John D'Arcy, NPA chief executive said: "I suspect this is a cock-up, but it brings a fundamental change. Expedient is a different word with a different meaning. To me it suggests it might be easier to get a contract granted."

The rules change, revealed exclusively in C+D, appears in the latest version of the National Health Service bill, passed by the House of Lords and awaiting Royal Assent (C+D, November 11, p6).

A wording change had been introduced to bring "legislative consistency" to the bill, claimed Richmond House. However, legal experts dismissed the DH line as "wholly unconvincing". David Reissner, partner with pharmacy law specialists Charles Russell, told C+D: "They [the DH] made a mistake and they should admit it. Parliamentary procedure does not allow changes to be made to legislation in a consolidation bill. Some might say Parliament has been misled, even if unintentionally, by including a change."

Pharmacy faces a period of instability unless the change is corrected, he added. "By making a serious error and then failing to correct it, the DH risks causing serious uncertainty when the Act comes into force in 2007," he said.

Opposition MPs pledged further scrutiny of the change. Sandra Gidley, Lib Dem MP, said: "There are broader principles at stake here: a) we have to work out what the impact will be on pharmacies, and how b) the government can tweak words in legislation and not think about the consequences."

John D'Arcy: may be easier to gain pharmacy contract under changed rules

Sandra Gidley: need to work out what the impact will be on pharmacies

## News in brief

### Taxing issues

HM Revenue & Customs has accepted the NPA recommendation for the effective date of implementation of rules for the VAT due in providing essential and advanced services and in particular the practice payment. For full details visit www.npa.co.uk/members

### Election shortlist

Voting for candidates for the RPSGB's English, Scottish and Welsh boards will take place from December 8 to January 12, 2007, the Society said. For details visit www.rpsgb.org.uk

### Gift bag gaffe

The MHRA has upheld a complaint made after medicinal products, including prescription drugs, were distributed to guests in gift bags at an awards ceremony run by Pharmacy Business magazine in October. The MHRA found that the company was in breach of medicines advertising regulations.

### Co-op 'library' launched

The Co-operative Group has launched packages of ready-made enhanced service specifications for primary care organisations.

The 'library' of services will include packages for services such as smoking cessation and EHC.

### Deadline for technicians

Pharmacy technicians have until December 31 to pay a practising fee of £93 or non-practising fee of £71. Those who miss the deadline will be removed from the register and must reapply for membership. Payment can be made online at www.rpsgb.org

### Update on shingles

Question two of the Update module 1384 is registering 'false' on the telephone marking syste when it should be true. A message has been placed phone answering ser of this. For Upd competitors wi challenging module will will not affect

# Steroid case prompts warning for pharmacists

## Legal Lloydspharmacy 'disappointed' with judge's ruling

Tom Hawkins

**Lloydspharmacy was locked in** talks with its legal counsel this week after losing a High Court compensation battle.

The retail chain, which is insured by the Chemists' Defence Association, faces a compensation claim of up to £5 million following the judgement on November 10. A ruling has yet to be made on the level of damages.

A spokesperson for Lloydspharmacy said: "We are very disappointed with the judge's ruling in this case and we are presently considering the question of an appeal with our legal advisors."

The claim was brought by the Reverend Cathy Horton, a lawyer from the USA, who was prescribed 28 days' supply of 4mg dexamethasone in July 2001.

The 4mg dose was repeated by a doctor on Mrs Horton's return to the USA, based on information on the label. This was eight times her normal 0.5mg dose for an adrenal deficiency and led to weight gain, moon face, puffy eyes, hair loss and depression, it was claimed.

A spell in The Priory clinic followed where she attempted to hang herself with a computer cable, the court heard.

Mrs Horton's counsel, Jeremy Stuart-Smith QC, said: "The effects of her steroid overdoses were cumulative and, by about early to mid September, she started to feel the effects."

Mrs Horton said the disruption to her life led to the failure of her fledgling business venture.

Mr Justice Keith said the error would have been discovered if N'Guessam Gabla, manager of the Lloydspharmacy at the time, had followed the branch manual and questioned the prescription.

He said: "In failing to do that, Mr Gabla fell below the standards which could reasonably have been expected of a reasonably careful and competent pharmacist."

Mr Gabla left the company late in 2001. His departure had nothing to do with the incident.

Mrs Horton has already settled an undisclosed damages claim against the GP that prescribed the 4mg dose, Dr Timothy Evans.

Mark Koziol of the Pharmacists' Defence Association said the case underlined the importance of maintaining best practice when dispensing steroids.

"As a learning experience, pharmacists should add steroids to the group of medicines they take special care over," he said.

**Strand News**

**All the Wight moves: an Isle of Wight pharmacy scooped two awards at this year's UniChem Pharmacy Awards held at the London Marriott Hotel. Gary Warner of Regent Pharmacy was nominated overall winner for his all-round commitment to the future of pharmacy, while Samantha Butler, dispensing technician, received the accolade for Most Supportive Technician in Community Pharmacy. David Badham of Stewart Pharmacy in Evesham took the Promotion of Healthcare Services within the Community award. The other two prize winners were Viv Farrell of Co-op Pharmacy in Stockport (Working in Partnership as part of a Healthcare Team) and Duncan Murray of CG Murray in Stourbridge (Enhancing the Shopping Experience). Pictured are John D'Arcy, NPA chief executive, and Mike Smith, chairman of UniChem, with overall winner, Gary Warner (centre)**

# RPSGB tackles fraud with new guidelines

## RPSGB Pharmacists urged to be truthful and accurate in NHS claims

**Pharmacists need to be truthful** and accurate in their NHS claims, the RPSGB has said in its latest law and ethics bulletin.

The Society gives particular guidance regarding:

- Prescription endorsements: must be checked for accuracy.
- MURs: pharmacists should check what constitutes an MUR if they are not sure.
- Other professional services: claims for locally agreed NHS services must reflect service provided.
- Patient declaration: pharmacists must check the declaration on the back of the prescription.
- Counterfeit/stolen prescriptions: pharmacists who report a fraudulent or stolen NHS prescription will receive a reward.

The Society has also issued several medicine alerts including:

- Pharmacists to exercise caution when dispensing oral methadone solution, and asks pharmacists to report any errors on their website.
- Pharmacists dispensing homoeopathic malaria remedies must make patients aware of the risks of not using recognised anti-malarial drugs. The advice follows calls by malaria and homoeopathy groups for customers visiting malaria risk areas not to rely on herbal remedies alone.
- The prescribing of controlled drugs for the treatment of addiction: pharmacists are reminded that only doctors licensed by the Home Office can write prescriptions for drugs, including cocaine, diamorphine and dipipanone for addiction.

For full details visit C+D's website www.dotpharmacy.com **JR**

# Future favours multiples

## Retailing Contract better for large chains

**The demands of the new** pharmacy contract – allied with the need to run a profitable concern – favour the large chain rather than the small independent, new research has said.

The report, The UK Retail Pharmacy Market 2006, notes that the UK's £12.8 billion retail pharmacy market is set for a period of strong growth, thanks to government initiatives to shift the emphasis from secondary to primary care.

The ageing population, a trend for self-medication and the new contract's emphasis on preventative measures will also play a role, the report states.

Multiples are tipped to make the most of the favourable factors, claimed report authors, Verdict.

Research analyst Maureen Hinton said: "Large businesses have the advantage of scale in IT implementation, best practice sharing, services marketing and contract negotiations for enhanced services. These factors reinforce the desirability for independent pharmacies to belong to an affiliate group." **AC**

# Hayfever drug downgrade

## Medicines Move to switch antihistamine to GSL

**Galpharm has applied to have its** antihistamine product – Galpharm Hayfever and Allergy Relief – reclassified as a GSL medicine.

The product, which contains cetirizine 10mg, will be for the symptomatic treatment of perennial rhinitis, allergic seasonal rhinitis and chronic idiopathic urticaria in adults and children aged over six years.

The company is proposing to offer the product in packs of seven and 14 tablets.

A GSL classification and larger pack size will make it easier for hayfever sufferers to get treatment that lasts for the duration of their reaction, says the company.

Responses to the MHRA consultation should be sent to veronica.popo@mhra.gsi.gov.uk by December 12. **JR**

How should you treat Bell's palsy? Turn to page 19 for the answers ›


# How a little TLC can make your customers feel more like themselves again


Every pharmacy wants to take care of their customers and the Care range helps you to do just that. As the days get shorter, it won't be long before you see all the familiar signs of winter coming through your door. So if you want your customers to feel really cared for this winter, and you don't want your pharmacy's profit margins to catch a cold either, ask your local representative about our fantastic deals for the winter season or call **01484 848200** for more information.

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# Day Lewis in MUR jackpot

## Practice Chief executive pledges £375,000 in staff incentives for conducting MURs


**Pharmacy group Day Lewis is pledging MUR prizes including:**
**£2.50 per MUR conducted for pharmacy teams**
**£5 per MUR conducted for pharmacists**
**£15K fund to be split between two Day Lewis pharmacists who conduct 150 MURs by March next year**
**Draw to be made for £10K first prize and £5K second prize**
**£375K total worth of MUR incentives offered by Day Lewis**

**Jennifer Rigby**

**Day Lewis has pledged almost** £375,000 in financial incentives to encourage staff to do more MURs.

Kirit Patel, chief executive of the pharmacy group, said: "We are doing this because I strongly believe that MURs are the foundation for pharmacists to provide future services. They will open doors for us."

Speaking at the Day Lewis awards and conference held last weekend, Mr Patel presented awards to his MUR pioneers, including pharmacists Kevin Watson (Outstanding Achievement for MURs) and Brian Soloman (Most improved Performance for MURs).

Day Lewis also announced its intention to focus on patient safety, and said it hoped to upgrade its EPOS system and install video technology in every branch to support staff with the challenges ahead. Day Lewis also won the Almus patient safety award at last weekend's UniChem Pharmacy Awards ceremony

Mr Patel also indicated his plans for expansion, hinting that Day Lewis would not remain a regional multiple for long, thanks to his intended acquisition next year of around 20 of the Alliance Boots shops that the group had to offload in the merger.

Open up pharmacy services, says Steve Dunn. See page 14 ›

# Pharmacist uses medicines campaign to boost MURs

## Practice Posters and banners encourage uptake

**Surrey pharmacist Raj Patel used** the recent Ask About Medicines Week to recruit patients for medicines use reviews at Mount Elgon Pharmacy in Kingston, Surrey.

Mr Patel used campaign posters to encourage customers to ask him about their medicines, if appropriate and the patient is a regular customer. Mr Patel said: "To date I have carried out 175 MURs and I aim to do three a day for the rest of the year so that I can meet the target of 400."

One of his patients, Elizabeth Martell, praised the service. "It was a very informative session and Raj was able to identify the tablet that was causing me a lot of distress. He wrote a letter to my doctor suggesting a change.

"I am feeling so much better now and I think more people should make use of their community pharmacist as they are easily accessible and know a lot about medicines." **JE**

# Alliance Boots is upbeat

## Retailing Extra pharmacies added and refits planned

**Alliance Boots has boosted its** pharmacy portfolio to 2,634, according to the healthcare group's interim results.

The firm added pharmacies to the end of September this year with a further 28 outlets operating and 152 subject to major refits, company figures revealed.

A fine British summer and continued growth in healthcare helped Alliance Boots register an "encouraging start" following its £7 billion formation this July, according to the healthcare group.

Plans to sell 96 pharmacies in accordance with the Office of Fair Trading's approval of its merger are "well underway", added Alliance Boots. Steps are also underway to introduce the Boots pharmacy brand to community pharmacies, said the company.

Overall, Alliance Boots recorded a 2.9 per cent rise in revenue to £7,039m with trading profit up 2.7 per cent to £267m, the six month results stated. **MG**

**The government's new £4 million hard-hitting sexual health campaign urges sexually active young adults to make condoms essential wear when they are out on the 'pull'. The ads target 18 to 24-year-olds because more than 80 per cent of them are at risk of a sexually transmitted infection, the DH said**


# 'NHS must be more political'

## Politics King's Fund professor says link is vital

**There should be more politics in** the NHS, not less, a source close to the prime minister has argued.

Faced with calls for an independent health board to run the NHS instead of the government in a debate held at health lobby the King's Fund's HQ, professor Paul Corrigan, the PM's special adviser on health, said: "Politics must exist in the NHS because in the last three elections it has been a major issue for the public. The link is difficult, because politics is seen as 'unsavoury' whereas the NHS has kudos.

"However, everyone believes in a nationally funded service which is free for all – so it is intrinsically bound up with taxation. And you can't take the politics out of taxation." **JR**

## News in brief

### NPA has trademark plan

The National Pharmacy Association has applied for exclusive use of the 'NPA' acronym for a variety of member services. The industry body is looking to trademark the use of NPA across services, including travel agency, financial and legal advice. The organisation has also launched a business management course and a guidance document for pharmacists this week. For full information see www.npa.co.uk

### PSNI fellowships

PSNI is inviting nominations for the awarding of fellowships to pharmacists who have distinguished themselves in their career. To find out more about nominating, go to www.dotpharmacy.com/psni/

### Female pharma event

The National Association of Women Pharmacists is holding its annual conference – Current developments in cancer treatment – between April 20 and 22 next year in Stratford-upon-Avon.

### Get info on your iPod

From next month, patients will be able to listen to product information leaflets on their iPod, MP3 player or computer, thanks to a scheme from the Royal National Institute for the Blind.

Patients will be able to download audio MP3 files from the X-PIL website, a medicines information website for the visually impaired, in addition to the existing formats of Braille, large print and CD.


- Over the counter (OTC) non-steroidal anti-inflammatory drugs (NSAIDs), such as ibuprofen and aspirin, are contra-indicated in people with gastrointestinal (GI) bleeding and ulceration.[1]
- When used regularly at OTC doses, ibuprofen and aspirin have the potential to cause serious GI problems.[2-8]
- The risk is exacerbated by factors such as age, smoking, alcohol consumption, or use of corticosteroids or anticoagulants.[4-6, 9]
- The active ingredient in Panadol (paracetamol) does not increase the risk of serious GI adverse events[4-6] is not associated with upper GI bleeding regardless of dose[10] and remains drug of first choice for patients with mild to moderate pain.[2, 4, 8, 10]

**The next time they need pain relief, be sure to recommend Panadol.**
**Panadol Tablets are for the relief of mild to moderate pain.**

References 1. British National Formulary. Edition 51, March 2006. Chapter 10: Musculoskeletal and joint diseases: Non-steroidal anti-inflammatory drugs. 2. Singh G. Am J Ther 2000; 7: 115–121. 3. Wilcox CM et al. Arch Intern Med 1994; 154:42-46. 4. Garnett WR. J Am Pharm Assoc. 1996; NS 6: 353-7. [illegible] McLaughlin JK. J Epidemiol Biostat 2000; 5: 137–142. 6. Peura DA et al. Am J Gastroenterol 1997 ; 92 : 924-928. 7. Biskupiak J et al. Abstract presented at the [illegible] Gastroenterology 70th Annual Meeting, 2005. 8. Schelman JM et al. Clin Gastroenterol Hepatol 2004; 2: 290-295. 9. Stiel D. Am J Ther 2000; 7: 91-98. [illegible] Pharmacol 2002; 54(3): 320-326

**Panadol Tablets Product Information. Presentation:** Each tablet contains Paracetamol 500 mg. **Uses:** Headache [illegible] and tension headaches, toothache, neuralgia, backache, rheumatic and muscle pains, pain due to non-serious arthritis, dysmenorrhoea, sore throat and feverishness [illegible] influenza. **Dosage and administration:** *Adults and children, 12 years and over:* Two tablets up to four times daily. Not more than 8 tablets in 24 hours. *Children 6–* [illegible] one tablet up to four times daily. Not more than 4 tablets in 24 hours. Not more than 3 days use in children without doctors advice. *Children under 6 years:* Not recommended [illegible] exceed the stated dose. **Contraindications:** Known hypersensitivity to ingredients. **Precautions:** Use with caution in patients with severe liver or severe hepatic [illegible] non-cirrhotic alcoholic liver disease. Caution required in patients taking warfarin or other coumarin anticoagulants, domperidone, metoclopramide, cholestyramine. Not to be [illegible] concurrently with other paracetamol-containing products. Use in pregnancy should be on doctor's advice. Not contraindicated in breast feeding. Arthritis sufferers should consult a doctor if they need painkillers every day. Sufferers from frequent headache should consult a doctor. **Side effects:** Paracetamol: rarely, hypersensitivity including skin rash, very rarely, reports of blood dyscrasias (not necessarily [illegible]). **Overdosage:** Immediate medical advice should be sought in the event of an overdose, even if the patient feels well, because of the risk of delayed, serious liver damage. **Legal** [illegible] 16's, GSL, 32's P. **Product licence number:** 00071/5074R. **Product licence holder:** GlaxoSmithKline Consumer Healthcare, Brentford, TW8 9GS, U.K. **Package quantities:** Compack 16's £1.39, Carton 16's £1.85, 32's £3.15. **Date of last revision:** May 2006. Panadol is a trade mark of the GlaxoSmithKline group. Superbrands is a registered trademark.

# Foster: the industry verdict

## PDA: no revalidation role for employers

Ailsa Colquhoun

**Employers should not be allowed** to play a significant role in investigation and revalidation, the Pharmacists' Defence Association has said in response to the Foster report.

Using evidence from environmental surveys undertaken following dispensing errors, the PDA reports that in the majority of incidents, the working environment has been a significant factor. "It is usually only the employer who can set the environmental conditions," it points out.

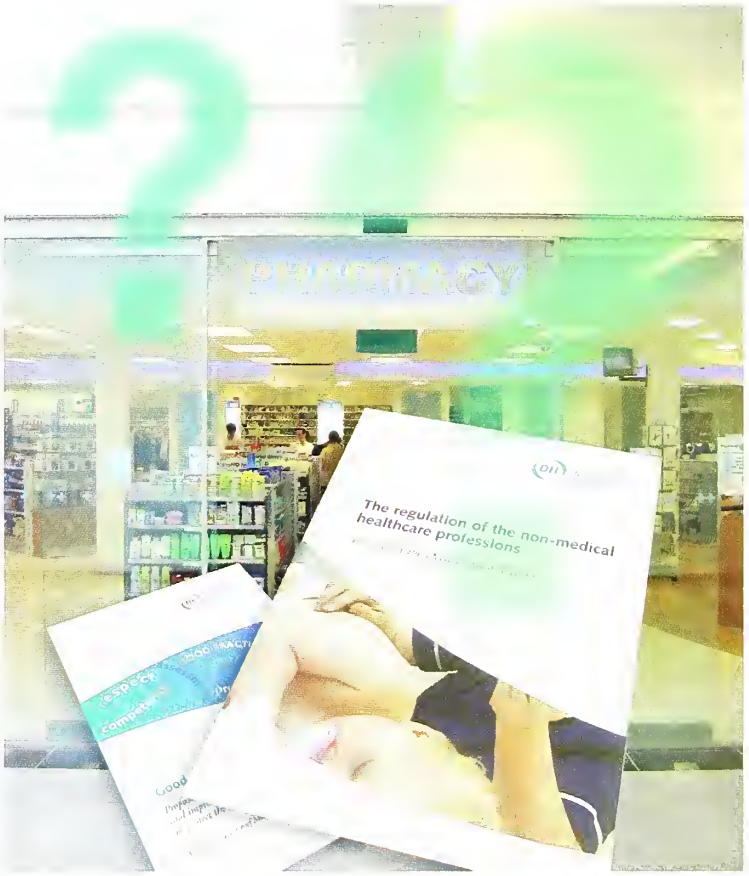
The PDA describes the current arrangements for the regulation of corporate entities as "woefully inadequate".

Employer participation in local investigations could result in an employer who is technically a co-defendant in a case of misconduct, undertaking a fitness to practise investigation into an incident with the primary objective of establishing the culpability of their employee. "Possibilities of conflict between employers and employees undoubtedly undermine the probity of any suggestion that employers should operate professional FtP investigations," say PDA chiefs John Murphy and Mark Koziol. "We find it astonishing that Foster advocates such a large role for employers in the regulatory process."

In general, though, the PDA has supported the need for an overhaul in the regulatory framework in pharmacy. "There needs to be a significant culture change moving from a punitive to a supportive learning culture."

Specifically, the PDA believes that the RPSGB should lose its dual functionality, although the membership body should retain a significant role in CPD.

The PDA also calls for the implementation of the current Section 60 Order to be suspended, while the responses to the Foster and the chief medical officer's reports are being considered.




## NPA: regulators must be free of the influence of professional interests

**The dual function of the RPSGB** has served the profession well over the years, but a regulator must be free of influence caused by professional interests, the NPA has said in its response.

Calling for a split in the professional and regulatory roles of the RPSGB, it says: "In reality, the Society has in recent times been moving in the direction of a regulatory role at the expense of being a professional body."

However, the potential for conflict of interest should not, of itself, be a reason for excluding an individual from a governing body. Commenting specifically on the proposal to appoint rather than elect professional members, the NPA says: "A blanket exclusion of representatives who have much to offer as a consequence of experience gained in other areas will result in that experience and insight being lost."

There should, however, be a professional majority, it adds.

The NPA also makes a number of other comments, notably that:

- In serious cases the standard of proof for fitness to practise should be no lower than the test in criminal cases – "beyond reasonable doubt".
- There should not be a reduction in the number of regulators.
- Revalidation should be proportionate to the risk posed.
- Protocols should be developed for determining at what level cases should be referred to the regulator.

The NPA favours regulators retaining responsibility for adjudication but through panels drawn from a central pool trained by the Council for Healthcare and Regulatory Excellence. **AC**

## King's Fund: team effort not addressed

**The Foster and the chief medical** officer's reports on the regulation of healthcare professionals fail to address how regulation will operate in an environment of devolution, team-based approaches to care, and new providers, a think-tank has said in its response.

According to the King's Fund, there is still a need to define a comprehensive system of professional regulation.

Two key questions remain to be answered:

- How can professional regulation be structured in order to best carry out its primary functions?
- How does professional regulation mesh with other systems of regulation?

Its report highlights changes in the way that healthcare is delivered, including:

- The boundaries between professions are being eroded.
- New roles are emerging that combine existing areas of professional expertise.
- Healthcare delivery is increasingly a team, network or system effort.

Among its recommendations, the Fund suggests that:

- There should be a system of regulation with common standards in which some functions are carried out by a single body. At a minimum, a single process of adjudication should be established with appropriate professional input.
- More work to enable a single professional regulatory system to deal with national differences.
- Regulators should be directly accountable to Parliament.
- Although a spectrum of revalidation across healthcare professions may be appropriate, it also needs to deliver on 'basics' such as ensuring that practitioners perform to agreed standards. **AC**

### HPC: extend regulation to other groups

The Health Professions Council (HPC) is calling for government to extend statutory regulation to other groups of healthcare support workers, including emergency medical technicians and assistant practitioners.

The Council, an independent UK-wide health regulator for 13 health professions, including chiropodists, podiatrists and physiotherapists, believes regulation should be consistent, flexible and enabling, UK-wide, targeted, risk-based and proportionate.

# Pharmacy education – the future

## The changing role of pharmacy has triggered a rethink of RPSGB education policy

Jennifer Rigby

**Pharmacy education needs to be reformed to better prepare future pharmacists for new roles, education chiefs have said.**

Speaking at the Principles of Pharmacy Education symposium in London last week, representatives from the Royal Pharmaceutical Society, industry and academia agreed that the time for reform is nigh.

Held jointly by the Academy of Pharmaceutical Sciences, the Academic Pharmacy Group and the RPSGB, the symposium was a chance to discuss the Society's 'Fit for the future' consultation, which is looking to rewrite the Society's education guidelines, from the indicative syllabus for undergraduates to the supplementary prescribing syllabus.

Dr Sue Ambler: wants a more joined up, relevant educational programme

Dr Sue Ambler, the Society's education policy lead, said: "We want to produce a more joined up, relevant educational programme but it is only the very early stages at the moment. We want to know what knowledge, skills, attitudes and values you think pharmacists need, and from that will flow what we teach and how we teach it."

Academics like Anthony Smith, the dean of the school of pharmacy at the University of London, said: "Before we think of reform, it is time to do a bit of navel gazing and discuss where our professional centre of gravity is. Yes, with the new contract we're patient focused – but we are medicines centred and it is hugely dangerous to move away from this too much educationally." He even suggested a move back towards science, and warned pharmacy education could lose its crucial government funding if he was ignored.

The academics also voiced concerns that the current degree programme is too isolated from the pre-registration year, and suggested a five-year integrated programme. Dr Ambler said: "We want to start by integrating thinking and values across pharmacy education so it is joined up intellectually. Whether this will lead to a physically joined up five-year integrated programme I don't know.

"The key thing is that pharmacists are now recognised as having a clinical responsibility for patients. What comes out of this won't be cheap in human or financial resources and the process could take at least 10 years," she said.

Academics mentioned their fears that the concept of 'oven ready' pharmacists – graduates who are ready to manage their own pharmacy from day one – was holding pharmacy education back. "If we can get over this idea of the super pharmacist, ready for anything on day one, lifelong education will open up to us," said Anthony Smith.

Dr Ambler agreed: "It's about a spiral of knowledge. First we need a line in the sand about where we can reasonably get people to at graduate level, then after their pre-reg year, and then other skills like prescribing, with wider knowledge, attitudes, skills and values every time."

Ian Bates, a professor at the University of London and editor of Pharmacy Education, advocated a structured postgraduate education programme. "It's easy to see how a five-year integrated programme could be beneficial – and we need to tackle disengagement with CPD too. We would like a formal postgraduate education structure."

Education experts dismissed the demand for 'oven ready' pharmacists

Professor Ian Bates: in favour of a five-year integrated programme

### Key points

- A five-year integrated education programme could be an option, including the undergraduate degree and the pre-reg year.
- Pharmacy education must retain its focus on medicine knowledge.
- Pharmacy education must be more joined up, from undergraduate onwards – perhaps with a structured postgraduate programme.
- An educational reform will not be cheap in human or financial resources, and could take 10 years to implement.

### RPSGB seeks your views

- What knowledge, skills, attitudes and values does the workforce need and at what level?
- What needs to be taught, learned and assessed when, where and how, and at what level, to ensure that the workforce is competent and fit to practise?
- What resource is needed to deliver appropriate teaching, learning and assessment and how should this best be organised?

*A consultation on education will seek your views early next year.*

Need advice on pre-reg training? Turn to page 29

# Your letters

## GPs and pharmacists – make love, not war!

**In recent weeks we have seen a** growing number of articles regarding GPs' concerns about the role of pharmacists.

GPs have also recently voiced their fears over pharmacist independent prescribing – citing patient safety as their main concern. I think we know that, realistically, this particular concern is unfounded and it is more likely that GPs feel threatened by pharmacists' expanding role.

There really shouldn't be any conflict – this is a real opportunity for the pharmacist and GP to work together, for the benefit of the patient, a bit like nurse prescribers and GPs.

Pharmacists will only prescribe within their areas of expertise after sufficient additional training. Let's look at Scotland – pharmacists are already doing it with their minor ailments service. Really, this is an example of independent prescribing and they have the backing of the GP!

If we work in collaboration rather than in competition it should be to the benefit of the health service and, of course, the patient.

If we work in collaboration rather than in competition it should be to the benefit of the health service and, of course, the patient

Our services should be complementary and when we work together the end result should be much greater, more efficient and provide a better service than if we work in isolation in our own worlds.

I think it all stems from when GPs no longer had to provide an out of hours service last year leading to many of them opting out. Although many pharmacies closed on Saturdays, as they no longer had sufficient prescription business to justify opening, others took it as an opportunity – a way of filling a gap.

There are all sorts of ways in which pharmacists can work with GPs:

1. Repeat dispensing – providing improved convenience for the patient and more efficiency for the practice. Look at the numbers of hours saved from both the patient and practice's perspective.
2. MURs – it is obviously of benefit to the patient to be reviewed annually, checking that the medicines

prescribed are used effectively. This can lead to a reduction in wastage and therefore a reduced drugs bill which ultimately benefits us all.

The MUR can also be used to identify those patients that require a full medication review, therefore helping GPs to make more points within their quality and outcomes framework. And we all know what points make – more money for the practice!

3. Minor ailments – if pharmacists see patients with minor ailments, this will free up the GP to look after patients with chronic conditions – patients who are probably more in need of time with their GP to discuss their condition without their appointment being rushed.

4. Public health messages/health promotion campaigns – GPs, pharmacists and other health professionals can work together to meet government targets. This is where a joint strategy would really benefit the consumer/patient.

5. Practice based commissioning – whenever this comes in, pharmacists can deliver real value for GPs. We have a number of skills that are not replicated in other healthcare professionals, particularly our knowledge of drugs and how they work – so use us, don't alienate us!

So the message is, we need to be working together, not fighting against the changes. But GPs aren't entirely to blame. There are too many pharmacists who are not engaging their local practices in their work nor developing the specific services that would help their local GPs.

I would certainly advocate greater communication between GPs and pharmacists, such as attending each other's meetings and keeping each other [illegible] development from their perspective. [illegible] provide a package [illegible] benefits the local community.

**Mimi Lau, director of professional services, Numark**

# University of Bath celebrates centenary

**I am writing to ensure that all** University of Bath alumni are aware of our centenary celebration plans.

The Department of Pharmacy & Pharmacology at the University of Bath is celebrating its centenary on July 4-7, 2007.

The Department would not have attained and maintained its excellence in teaching, and its international reputation in research, without the contributions of so many former staff and students.

I am particularly keen that no-one is omitted from our centenary celebrations and we therefore want to publicise the event as widely as possible.

We are asking all our alumni to reserve these dates in July. On July 4 and 5 we will celebrate our prowess in the pharmaceutical sciences, while on July 6 we will focus on our excellence in the practice of pharmacy.

The centenary event for our alumni will be held on Saturday July 7, when we hope to 'meet and greet' as many former colleagues and students as possible. Details of the entire programme can be found at www.bath.ac.uk/pharmacy/centenary/index.shtml

Please register now for the event by contacting Maggie Pearce at prsmap@bath.ac.uk or via the link on the above website.

**Richard H Guy, PhD, Professor of Pharmaceutical Sciences, head of Department, University of Bath Department of Pharmacy & Pharmacology**

C+D welcomes letters from readers. You can email them to chemdrug@cmpmedica.com, fax them on 01732 367065 or post them to us at C+D, CMP Information, Sovereign Way, Tonbridge, Kent TN9 1RW.

Please include your name, job title if appropriate, your address and a contact number where we can reach you should we need to discuss the content of your letter.

Letters may be edited for length and/or content.

# Comment from the editor

## Take note as pharmacy legal dramas unfurl

**From Perry Mason to Ally McBeal, nothing** beats a good legal drama. Except of course when it directly affects us. And this week pharmacy is intimately involved in one legal dispute and looks likely to become embroiled in a second.

In the first case, an American lawyer has won the right to compensation from Lloydspharmacy after a judge ruled a pharmacist had negligently dispensed a prescription.

Even though such mistakes are fortunately few and far between, there cannot be a pharmacist among us who has not experienced that sinking feeling on realising that a mistake has been made (or even a very near miss).

Yes, it is best practice to check when a patient presents a prescription for something a little out of the ordinary but with almost all pharmacies facing ever increasing workloads what is the best way to achieve this? For those with good relations with their local surgery, a telephone call can be a quick option. But for city-based pharmacies that attract customers from a wide area, or when patients present late at night or at weekends, how can pharmacists make the appropriate checks?

Perhaps when the NHS's IT programme is finally up and running, pharmacists will be only a click away from checking a patient's medical record, a moment that cannot come too soon. But one wonders how pharmacy-friendly the NHS IT solution will be. Only this week C+D tried to speak to a pharmacist on the NHS IT programme's pharmacy user group to be told that they couldn't speak as there was a confidentiality agreement in place – not a comment that fills one with confidence about the way ahead.

The week's second legal issue is comical but no less serious in its consequences. As C+D exclusively reported last week, the 'necessary or desirable' criteria for pharmacy contract applications has been changed to 'necessary or expedient'. The DH says the change was made to ensure "legislative consistency", a statement that is "wholly unconvincing" according to a senior pharmacy lawyer.

There is talk of the DH issuing 'rules' to PCTs to ensure that expedient is interpreted as desirable. But when rules do not reflect the original Act they are effectively useless: in a court of law surely Acts take primacy over rules as only the former has been debated and agreed by Parliament? Until the original criteria is reinstated, the only winners are likely to be the lawyers.

There cannot be a pharmacist among us who has not experienced that sinking feeling on realising a mistake has been made

# Your views

## Take up Lord Warner's challenge

**Steve Dunn says pharmacists should welcome the latest call on PCTs to open up patient services to new providers**

**Another voice has joined the call** to PCTs to open up patient services to new providers – and it should be welcome news for all pharmacists.

The latest call has come from Lord Warner, speaking to PCT executives at the National Association of Primary Care Conference. He said that PCTS in all areas, not just those in traditionally underserved areas, should invite commercial and third sector providers to supply services for patients under the NHS banner.

PCTs, says Lord Warner, must move service delivery forward. The NHS must seek out continuing enhancement in the services patients receive and how they access them.

This should be music to the ears of pharmacists. Already we have had Andy Burnham's announcement that the role of expert pharmacists has received the government's go-ahead, enabling pharmacists to provide care and advice about conditions such as diabetes and STIs.

Now PCTs are to look for new suppliers of healthcare services in the community, and who is better placed to provide these than pharmacists?

Pharmacists have many advantages over other potential providers. They are located in the heart of their community, accessible by everyone without the need to book an appointment and they are trusted.

As well as having the expertise based on years of study and experience, they are familiar with the healthcare issues in their community, particularly those not being met through current service provision. Who is better placed to identify what is needed and offer a solution?

Some pharmacists have already entered this brave new world, providing services from BP monitoring to smoking cessation, from EHC to warfarin clinics.

The only difference between them and the majority of pharmacists is that they have already grasped the opportunities opened up by the new contract – and are now benefiting financially and professionally.

If they can do it, so can you. Just pause for a moment and think about what additional services your patients need. I am sure you can identify at least one that you can provide. Then put together your case, and approach your PCT. The pressure on them to open up services is becoming so strong that you should find a receptive audience.

There is also plenty of support available from companies. AAH has a primary care team already engaging with PCTs and LPCs to identify opportunities, and even more importantly we can help you with training, equipment and advice to enable you to deliver your chosen service successfully.

The opportunities to provide healthcare services in the community are here, right now, and pharmacists must seize them quickly. If you do not, you can be sure that commercial vendors will, and the opportunity will be lost for ever.

**Steve Dunn, group managing director, AAH Pharmaceuticals**

# Xrayser

Topical Reflections

## The drugs don't work

**Despite increasingly frequent warm** words from government, it is not particularly interested in funding pharmaceutical care, only ways of squeezing us for all we are worth. Splitting bulk supplies of methadone mixture into daily amounts is one of the easiest and cheapest ways pharmacists can contribute to healthcare. Yet the Department of Health no longer pays us even for this (C+D, November 11, p6).

Of course drug addicts will not, and probably cannot, accurately measure daily doses. I needed three A levels before I could even take part in those dispensing lessons that taught me the importance of getting that meniscus dead on the line of the conical measure. Years of practice later I'm a dab hand, but even I would find it difficult while suffering from the DTs. And nobody can measure eight or 12ml with a 5ml spoon.

Some could argue that pre-measured quantities are easier to sell on, but those intent on selling their supplies will do so however they are presented. In contrast, those taking methadone prescribed for someone else are likely to finish the bottle, however much it contains.

Methadone patients are notoriously likely to 'drop' and smash their bottle on the way home, demanding further supplies. There's no antidote to some GPs' naivety but seven individual bottles are much less likely to get 'dropped' than one big heavy one.

Pharmacists' input in methadone supply has made an enormous difference to the lives of thousands of some of the most vulnerable people in society. Supplying daily volumes is just one example. I have spent huge amounts of time providing the best possible service, whether it's making special arrangements with a GP, supervising doses or putting up with dreadful verbal abuse.

And all this has been done at little or no cost to the DH. There can't be many better value for money NHS services. To discover that some of my existing payment is being withdrawn feels like an awfully big slap in the face. I am a great servant to the health service, not a charity. If I am to contribute any more, the DH must start putting its money where its mouth is.

## A roller coaster of a week

**Pharmacists like to moan, and I'm no** exception. But if I'm honest, the average week is more like a roller coaster ride than the road to hell. There are lots of ups and downs, and sometimes there are even more ups than downs.

One of this week's yuckiest downs involved donning latex gloves to dispose of a pile of patient-returned CDs. Sticking Durogesic patches to themselves is one of my most unpleasant, and undoubtedly dangerous, chores. But the fun bit is adding the water to the denaturing pot and watching it congeal into a brightly coloured sticky mess. I would have loved one of those in my chemistry set as a kid.

On a less selfish note, my disappointment at not being part of an EHC patient group directive was tempered by the satisfaction of getting a 14-year-old an immediate appointment at the local family planning clinic. The extremely anxious girl only had a half an hour window before she had to meet her mother (who she was unable/unwilling to tell) and if she hadn't come into my pharmacy I dread to think of the consequences.

CD

## Consultation, no consultation

**Somewhat like buses and taxis,** you see none for ages then several come along at once – not patients, consultations. These, plus an increasing number of contract applications exploring the limits of the control of entry exemptions, are filling the inbox and task lists. Still, perhaps we should be grateful to have the opportunity to comment on anything that might impact significantly on our future way of working. With Foster and Donaldson, Section 60, control of entry, various attempts to 'simplify the tariff' (ie 'save money') and the APPG enquiry, it continues to be a time of change for our profession and healthcare in general.

What disappoints me is the apparent lack of interest in all this among grass root pharmacists and contractors. After all, if they do not care about the future of their profession then who can really blame those who decide the outcomes of such initiatives for

What disappoints me is the apparent lack of interest in all this among grass root pharmacists...

presuming we do not mind in which direction we go or where we end up?

One area where consultation was sadly missing is the home oxygen service. There are many unanswered questions in high places about the quality of the resultant service and a decommissioning proposal where we do not know what the real financial outcome is when submitting claims.

I listened with interest to some excellent presentations at last month's community pharmacy conference in Birmingham. The health minister was lacking in any detail and unwilling to direct PCTs to commission services from pharmacy yet that process seems to happen all the time for GPs. Sandra Gidley gave a stimul... speech, shame that Andy ... missed most of the bes' bi... could not stay around ... to respond. Collabo... be the buzz word

**Written by an I...**

# Pharmacy Champions


Name
**Kate Forsey**

Pharmacy
**Lloydspharmacy, Bellingham, South East London**

What has she done?
**Set up a community based anti-coagulation service**

**What have you set up?**
Lloydspharmacy in Bellingham was one of two pharmacies that ran a pilot anti-coagulation service for three to four months. This was completed successfully and expanded to run in six pharmacies across Lewisham PCT. Clinics are held within the pharmacy every Monday morning and are currently attracting between 15 and 20 patients each week. After a bank holiday, we would run the clinic on Tuesday.

The patients are recommended to attend the anti-coagulation service by the haematology department at University College Hospital and referred with the permission of their GP.

During each session, an accredited pharmacist takes and analyses a blood sample to check INR levels and reviews the patient's current dosage of warfarin. Depending on the outcome, the patient will be booked for a follow-up appointment for the next week if they need closer monitoring. Otherwise the follow-up would be within 12 weeks.

**Were there any difficulties?**
It has been a learning curve. For example, while the dosing element came more naturally to both my colleague David Murty and myself, it took a bit of practice to get our finger pricking technique up to scratch. However, we had plenty of support and practice sessions, both on co-operative colleagues and consenting volunteers at the hospital.

It can be difficult to get a blood sample sometimes, particularly from elderly patients who have cold, white hands. We have learned to get round this by asking them to wear gloves when it's cold or use a heat pad to encourage better circulation.

**How have the locals reacted?**
They tell us they like the fact that we offer them an appointment slot in which we do the whole service in one go. They can be in and out in 10 minutes because we deal with much smaller volumes of patients than the hospital. Our service saves them from having to go to the hospital and put up with the transport and parking issues associated with that. Professionally it's very satisfying as we're offering patients a choice and improving their quality of life.

I also think it enhances our relationships with patients and raises our profile within the community.

Lewisham PCT has shown its appreciation of the service by awarding us an award for improvement, creativity and innovation at its AGM late last year.

**Any advice for others?**
In the first instance, talk to your PCT about what community-based services you may be able to help with. I'm sure anti-coagulation, which is listed as an enhanced service in the new pharmacy contract, will become increasingly popular as PCTs and hospitals realise the benefits of delegating this to community pharmacy.

Nominate your Pharmacy Champion:
Telephone 01732 377688
or email chemdrug@cmpmedica.com

# Changing the way we supply our medicines

## The need for change

We are changing the Pfizer UK supply and distribution arrangements to allow us to take full responsibility for our medicines from the point at which they leave our manufacturing centres until they are sold to our customers who dispense them.

As the major supplier of medicines to the NHS, we are very aware of, and increasingly concerned about, the complexity of the supply chain and the implications for our medicines. We are confident that as a result of our changes Pfizer will:

- be better able to manage supply and be more responsive to stock-shortage situations so that pharmacists and patients are better able to obtain Pfizer medicines
- reduce the risk of counterfeit medicines by securing the distribution of the supply chain so that pharmacists and patients can be confident they will receive genuine Pfizer medicines from Pfizer
- have improved visibility over the supply chain, and be better able to trace and recall Pfizer medicines with complete confidence if and when required

Under the new system, pharmacists will be able to buy Pfizer prescription medicines directly from Pfizer with complete confidence.

## Working with pharmacists

Pfizer believes that pharmacists are increasingly important customers. The new distribution arrangements will enable us to get closer to pharmacists and over time develop a beneficial partnership.

We will continue to maintain our substantial financial investment in distribution and continue to offer cash discounts because this is what pharmacists have told us they want.

Over time, our intention is to develop a wider range of other service-based offerings for pharmacists, based on analysis of customer needs and the new pharmacy contract.

## How will it work?

- Pfizer prescription medicines will be distributed by UniChem Limited
- Pfizer and UniChem will jointly ensure full coverage for all new and existing UK customers, and ensure current service patterns are maintained

## Next steps

We anticipate that the new arrangements will go live in the first quarter of 2007. Over the next few months, we will ensure we communicate with pharmacists to help them understand the changes. This communication will be driven by the Pfizer pharmacy team and through the pharmacy media.

If you already have an account with UniChem, there will be minimal changes. If not, Pfizer and UniChem will be contacting you shortly to explain the changes further and support you through the sign-up process.

We understand that you will have questions and possible concerns over this change. To find out more, please log on to **www.pfizerdtp.co.uk** or call our dedicated pharmacy customer service team on **0845 608 8866** who can put you in touch with your local pharmacy representative. No further information is available on the discount scheme at this point.


DTP008b, August 2006.

C+D

Chemist+Druggist

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Published Saturdays by CMP Information Ltd, Sovereign Way, Tonbridge, Kent TN9 1RW

C+D on the internet at: http://www.dotpharmacy.com/

Subscriptions: (Home) £173 per annum; (Overseas & Eire) $412 per annum. Single copies C+D £3.50 (postage extra). Extra Price List for subscribers: £16 per single copy; for non-subscribers: £55 per single copy. Subscription plus additional Price List: UK £173 plus £120; overseas: $412 plus $205.

Circulation and subscription: CMP Information Ltd, Tower House, Sovereign Park, Lathkill St, Market Harborough, Leics. LE16 9EF. Telephone: 01858 468811 Fax: 01858 434958

Refunds on cancelled subscriptions will only be provided at the publisher's discretion, unless specifically guaranteed within the terms of subscription offer.

The editorial photos used are courtesy of the suppliers whose products they feature.

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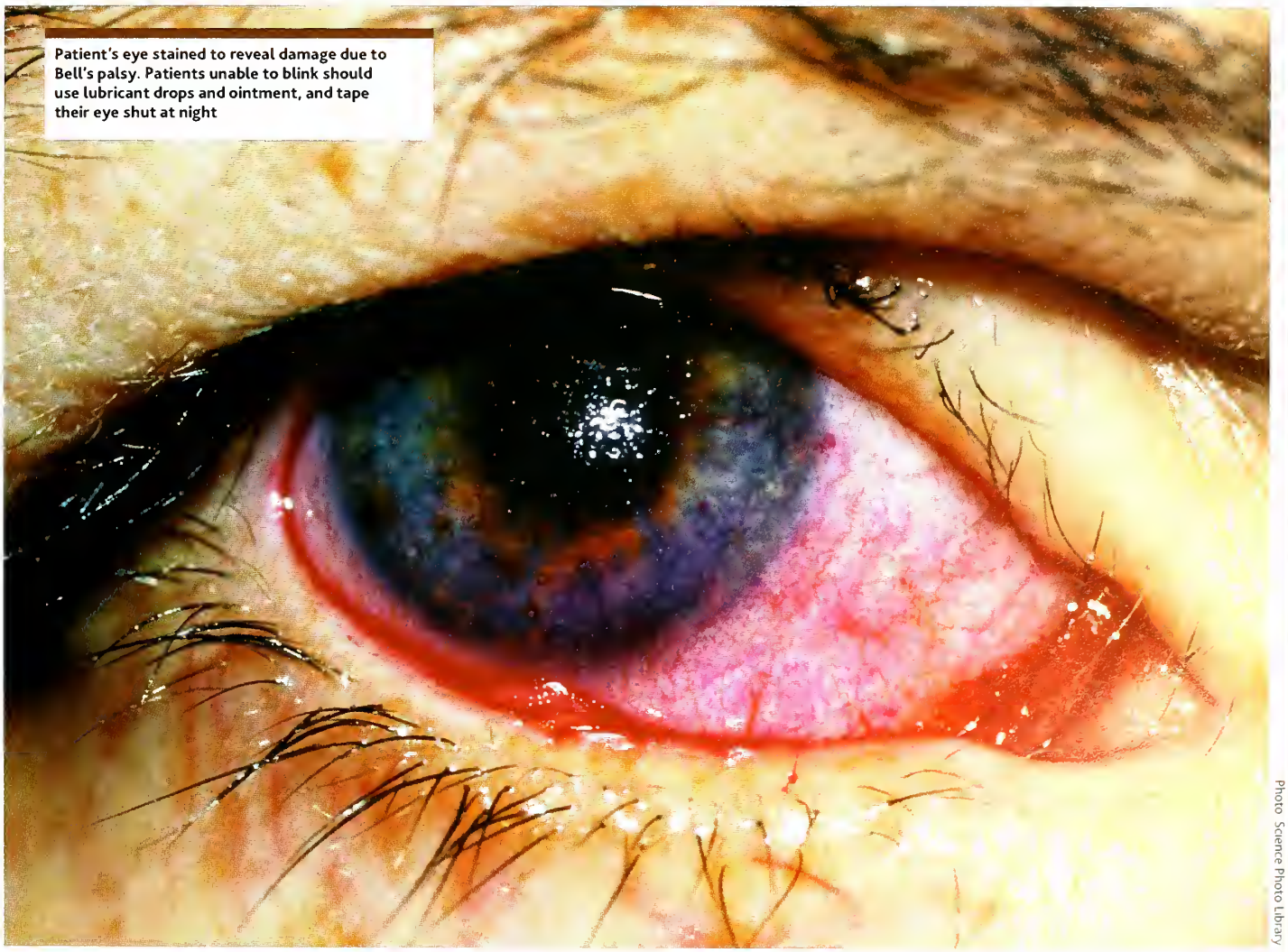
# C+D Clinical

# The lopsided face

C+D describes the symptoms and treatment of Bell's palsy



Patient's eye stained to reveal damage due to Bell's palsy. Patients unable to blink should use lubricant drops and ointment, and tape their eye shut at night

Photo Science Photo Library

**Vanessa Sherwood**

Esther MacLean is a long-standing customer of your pharmacy. Although she's not considered a 'regular', you've been seeing more of her recently as she has been caring for an elderly relative, so she frequently comes in to collect prescriptions and ask for advice.

At the end of a busy lunchtime you begin checking prescriptions that will be collected later. You're surprised to see one for Esther.

The prescription reads:

*Prednisolone 60mg daily for five days then reduce by 10mg daily until finished. Mitte 90.*

Checking the PMR you can see that Esther has only ever had the occasional antibiotic from you and has no asthma or other inflammatory conditions.

When Esther calls in to the shop later in the afternoon you can immediately see what's wrong: her face looks lopsided.

The GP told Esther that she has Bell's palsy.

## What is it?

Bell's palsy is named after Charles Bell (1774-1842) a Scottish surgeon who served at the Battle of Waterloo.[1]

Bell's palsy is a one-sided facial paralysis that starts suddenly; many sufferers wake up with the condition. The paralysis leads to muscle weakness and problems with facial expressions and eye closure

## The College of Pharmacy Practice

This course (module 1387), in association with multiple choice questions being published in C+D December 2, provides one hour's continuing education

CPD

This [illegible] the [illegible] competency G1c, [illegible] www.[illegible]

may become more sensitive to loud noise and may lose their sense of taste on the side of the tongue that is affected.[2] There may also be facial numbness, tingling, twitching and pain. Occasionally it may be preceded by earache.

The paralysis is thought to be caused by inflammation of the seventh cranial nerve (facial nerve), which controls functions such as blinking and chewing.

## How common is it?

Bell's palsy occurs in about 20 in 100,000 people every year.[3] Men and women are equally affected but there does appear to be an increased incidence with age. It is also more common in people with diabetes and pregnant women. Children are rarely affected. It will recur in about one in 10 patients.

## Script counselling

You take Esther to the counselling room to go over the new prescription with her. You can see that she's upset. When she woke up that morning and looked in the mirror she was afraid she'd had a stroke. She managed to get an appointment quickly with her GP who, after examining her, diagnosed Bell's palsy.

"The doctor says that he was going to give me something for inflammation but what about my droopy face?" she asks.

You explain to Esther that the prednisolone has been prescribed as an anti-inflammatory to reduce any possible inflammation in the facial nerve (see Evidence for Treatment above right).

After counselling her on the prescription you mention that it is also important to look after the affected eye by using lubricant drops such as hypromellose during the day and a lubricant eye ointment at night. Until she can close her eye properly she should also tape her eye shut at night using a paper tape. She wears glasses for driving and watching television and you encourage her to wear them more frequently until she's better.

"When will that be?" she asks despairingly.

## Prognosis

Around 80 per cent of patients make a complete recovery from Bell's palsy, even without treatment, in two or three weeks.

Some people may take three or four months to recover completely and a small percentage (five to 10 per cent) will be left with lasting symptoms. If the paralysis was incomplete and/or symptoms start to improve within the first week then this is usually a good indicator for complete recovery.[5]

## Other causes of facial paralysis

Any patients complaining of facial paralysis should immediately be referred for a correct diagnosis. Bell's palsy is easily diagnosed in primary care and does not usually require a hospital referral. Other causes of facial paralysis may need further investigation and treatment. These include:

- Stroke – usually accompanied by other systemic features.
- Ramsay Hunt syndrome – a herpes zoster infection. Vesicles are present in the ear and/or throat.
- Facial nerve tumours.
- Parotid tumours.
- Lyme disease – also has skin and joint signs.
- Mastoiditis (infection and inflammation of the mastoid bone behind the ear canal) – is accompanied by deafness and discharge.
- Meningitis.
- Brainstem lesions such as multiple sclerosis – usually accompanied by other neurological signs.[6]

## Evidence for treatment

Even without treatment most people will make a full recovery within three weeks so why would the GP prescribe prednisolone?

The pharmacological treatment of Bell's palsy, along with the cause of nerve inflammation (see below) appears to be a highly controversial topic. Some of the main studies are summarised in Table 1 (above).

For Esther, a healthy woman without pre-existing medical conditions, the GP's decision to treat Bell's palsy of recent onset with prednisolone is reasonable.

## Is herpes simplex the culprit?

There seems to be much controversy surrounding the cause of the nerve inflammation that leads to Bell's palsy. Most often the herpes simplex virus that causes cold sores is thought to be to blame. As a result, patients have been treated with antiviral medication such as aciclovir, either alone or in combination with steroids.

In summary, the research so far says:

- Rowlands *et al*: "Lack of household clustering and a lack of tendency of herpes simplex infections to precede Bell's palsy do not support a viral aetiology."
- Grogan *et al* said that aciclovir is "possibly effective" in improving outcomes.
- Shannon *et al* concluded that adding aciclovir to steroids may improve recovery rates compared with steroids alone.[7]
- Holland and Weiner, 2004, in a Clinical Review published in the British Medical Journal, said. "Increasing evidence implies that the main cause of Bell's palsy is latent herpes viruses (H simplex Type 1 and H zoster)" and "treatment with antivirals seems logical".[10] However, this article prompted a flood of letters about the evidence, or lack thereof, for the authors' conclusions.

The good news for confused pharmacists and GPs is that there is currently a study underway at Dundee University. The Scottish Bell's Palsy Study, a national randomised clinical trial, aims to assess the difference in outcomes in four groups of patients:

- Patients treated with prednisolone.

### Table 1: Evidence for treatment

- Rowlands *et al*, 2001 – "At present, it is uncertain whether or not drug treatment is effective in Bell's palsy. This doubt is clearly reflected in GPs' prescribing habits."
- Shannon *et al*, 2003 – "Overall the data suggested corticosteroid therapy may provide a small clinical benefit in adults."[7] This paper also quotes a US physician, Steven Horowitz. He says: " My practice of neurology began before the era of corticosteroid treatment for Bell's palsy. Despite the lack of convincing evidence-based data, it is my clinical impression that there are far fewer patients today with incompletely resolved Bell's palsy than before the widespread use of steroids."
- Grogan *et al*, 2001 – "Available evidence suggests that steroids are probably effective in improving facial functional outcomes. Well-designed studies of the effectiveness of treatments for Bell's palsy are still needed."[8]
- Bandolier 2002 – A systematic review of two studies concluded: "Treatment of Bell's palsy with adequate doses of oral steroids for about a week soon after onset will help between 10 per cent and 20 per cent of affected persons to complete cure over four months."[9]

### Table 2: Prednisolone points

- Prednisolone must be taken with food.
- Apart from the first dose, which should be taken as soon as possible, prednisolone is normally taken in the morning. The British National Formulary states that "the suppressive action of a corticosteroid on cortisol secretion is least when it is given as a single dose in the morning".[4]
- Prednisolone should be used with caution in patients with pre-existing peptic ulcer disease, uncontrolled diabetes, hypertension and immunosuppression.
- For a short course patients should be reassured that the side effects, such as weight gain and Cushing's syndrome, are unlikely.
- Short-term side effects may include indigestion, insomnia and increased appetite.
- For courses less than three weeks long a steroid card is not required as these doses can be halted abruptly.

- Patients treated with aciclovir.
- Patients treated with both.
- No treatment.

Patient recruitment was completed this summer and the study runs until June 2007.

## Long-term complications

In the small percentage of patients who do not make a complete recovery from Bell's palsy the long-term effects may include:

- Facial neuropathic pain.
- Eye problems caused by dry eyes as a result of a damaged blink reflex.
- Motor synkinesis (involuntary movement accompanying a voluntary one) eg blinking may make the mouth twitch.
- Autonomic synkinesis – involuntary lacrimation after a voluntary muscle movement.

## Continuing professional development CPD

### Reflect

Do you know what Bell's palsy is? Have you ever come across anyone complaining of a facial paralysis? What condition did you suspect and, if you were asked for advice, what did you recommend?

### Plan

If you feel you need to know more about Bell's palsy, this article describes the signs and symptoms, possible causes, treatment, prognosis and advice to give the patient.

### Act

- The diagnosis of Bell's palsy is fairly simple but the article draws attention to other potential causes of facial paralysis. Make certain you are familiar with these.
- Look at the following two websites: http://www.bellspalsy.com/facialparalysis.htm, http://www.studentbmj.com/issues/05/07/education/284.php as well as the site mentioned in the references: http://www.jr2.ox.ac.uk/bandolier/booth/neurol/Bellsyre.html
- Find out if there is any new work on the causes or treatment of this condition.
- Make sure you can give advice on home treatment, especially eye complications.

### Evaluate

If you had any Bell's palsy patients could you reassure them, having read the article? What would you say to them in the first week, after a month and if some of the symptoms persisted after six months? Do you feel more confident now?

## Esther's outcome

You didn't see Esther for a couple of weeks as she'd told you she felt embarrassed by her appearance. However, she continued to improve and had made a complete recovery after four weeks.

Vanessa Sherwood, BSc, MRPharmS, is a freelance writer, formerly clinical editor, Chemist + Druggist.

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## Key points

- Bell's palsy is a one-sided facial paralysis of unknown cause.
- Symptoms include numbness, twitching and a lack of control of facial movements such as chewing, blinking and tears.
- Patients should be referred to rule out any other cause.
- Pharmacological treatments are controversial – short doses of prednisolone are probably effective if given early, and safe for patients without pre-existing medical conditions.
- Non-prescription treatments, such as lubricant eye drops and ointments, are an important part of care.
- Pharmacists can reassure patients with incomplete paralysis that they have a good chance of making a quick and complete recovery.

# Distance learning for pharmacists

Pharmacists using Pharmacy Update for continuing education are reminded of the need to test. With the support of Genus Pharmaceuticals, C+D readers can self-test their progress by using the multiple choice question (MCQ) paper to be inserted in the December 2 issue, which will cover this week's CPP-accredited module, together with those in the November 4 and 11 issues.

These will cover
- Preventing CV disease (1385)
- Interpreting clinical trials (1386)
- Bell's palsy (1387)

A telephone marking service offers independent verification of results (see the monthly MCQ papers in C+D for details). If you wish to register for Pharmacy Update, please contact Pauline Sanderson on 01732 377269

Chemist + Druggist
in association with
Genus Pharmaceuticals

C+D

# Chlamydia screening a success for pharmacists

Pharmacists are playing an increasingly important role in chlamydia screening, according to an annual report from the national programme.

As well as providing a venue for collecting kits, some pharmacies are arranging and delivering treatment and contact slips.

Between April 2005 and March 2006, the third year of the programme, nearly 100,000 screening tests were carried out, the National Chlamydia Screening Programme Steering Committee reports.

The disease burden remains high, with one in 10 men and women testing positive for the infection.

But almost 100 per cent of those testing positive were treated, 83 per cent in a setting other than a GUM clinic.

Since 2003, 180,000 screening tests have been conducted in venues outside of GUM.

The past year also saw an increase in the number of men screened, which now stands at 18 per cent compared with only 7 per cent of those screened in the first year, due to better targeting and special events at venues such as youth clubs.

Figures also show that positive levels were highest in black ethnic groups at 14 per cent and lowest in Asian and Chinese populations, at 4 and 8 per cent respectively.

The national programme for the under 25s is now in phase 3 and covers 85 areas in England.

# SSRIs act faster than thought

Treatment with SSRIs leads to improvement in symptoms of depression within the first week, a large meta-analysis has concluded.

The findings counter the established view that there is a delayed onset of effect of the drugs in patients with depression, with patients having to wait two to three weeks for any benefit.

A team of US and UK researchers analysed data from 50 trials that reported outcomes for at least two time points in the first month of SSRI use.

They reported that treatment with SSRIs was associated with clinical improvement after the first week of treatment compared with placebo. A secondary analysis revealed patients on SSRIs had a 64 per cent increased chance of halving Hamilton Depression Rating Scale scores by one week with SSRI treatment compared with placebo.

After the first week, symptoms continued to improve but at a decreasing rate for at least the six-week period analysed by the researchers.

The researchers said separating out the drug and placebo effects show the early benefits are from the treatment itself.

They estimate one third of the treatment effect seen after six weeks occurs in the first seven days.

"Treatment with SSRIs is associated with symptomatic improvement in depression by the end of the first week.

**Researchers found that about a third of the treatment effect of SSRIs occurs in the first seven days of taking them, contrary to the established view**

"An early response is not necessarily a placebo response," they concluded.

**For more information:**
Archives of General Psychiatry 2006; 63:1217-23

## A Practical Approach... last week's answers

1. Mr Ross's diarrhoea and nausea could be the result of an interaction between lithium and ramipril, an ACE-inhibitor, causing a rise in serum lithium to a toxic level. Diarrhoea and nausea are early symptoms of overdose. Mr Ross's serum lithium needs to be checked immediately and the dose adjusted before more serious consequences of overdose occur.
2. David should not recommend anything, as the symptoms may be the result of lithium toxicity. However, he did contact Mr Ross's GP for fast referral, who may decide to reduce the lithium dose pending results of the blood test, and possibly consider symptomatic treatment.

## A Practical Approach...


**David Spencer, the pharmacist at the Update Pharmacy, gets a phone call at home one evening from Salma Hussein, who until recently was his pre-registration pharmacist trainee. She has now qualified and is working as a locum to broaden her experience.**

"David, I hope you don't mind me calling," says Salma, "but I've got a problem I'd like your advice about."

"Of course I don't mind. How can I help?" David replies.

"Well, I'm doing a few days in a small pharmacy that's owned by a non-pharmacist, and he's there working in the shop. I've noticed that codeine linctus is kept under the counter. While I've been working in the dispensary, a few times I've seen people come in and apparently ask the owner for something, but he says something to them and they go away. I was a bit suspicious, so before I went to lunch today I nipped out while he wasn't looking and counted the bottles of codeine linctus. I counted them again when I got back and there were four fewer. I'm sure he must be selling them while I'm out. I'm so worried, David, I just don't know what to do."

"Have you contacted the superintendent pharmacist?" asks David.

"He's the owner's son, and he's away on holiday anyway."

"How much longer are you working there?"

"Just tomorrow."

"Well," says David, "here's what I think you should do."

**Questions**

1. What advice would you give to Salma?
2. What are a pharmacist's ethical responsibilities in this situation and what help or guidance does the Royal Pharmaceutical Society provide?

CPD

This article can help in the following CPD competencies: G1g, G1h, G2a, G2e, G2i, G2j, G2k, G3a, G7a, G7c See www.tinyurl.com/194zu

In the majority of cases, patients with anal fissure are currently referred to and treated in secondary care. But a recently published European-wide treatment algorithm, the first of its kind, aims to optimise the management of anal fissure through the earlier use of topical medication in primary care.[1]

### What is an anal fissure?

An anal fissure is a small tear in the lining of the anus. Although very small, it can be extremely painful because the anus is particularly sensitive.[2] The pain tends to be worse when faeces are passed and may last for several hours.[2,3] Anal fissures often bleed a little and this may be noticed after passing faeces.[3] The blood is usually bright red and stains the toilet paper, but soon stops.[2,3]

A fissure is described as acute if it has been present for less than 6 weeks and as chronic if it has been present for more than 6 weeks.[3]

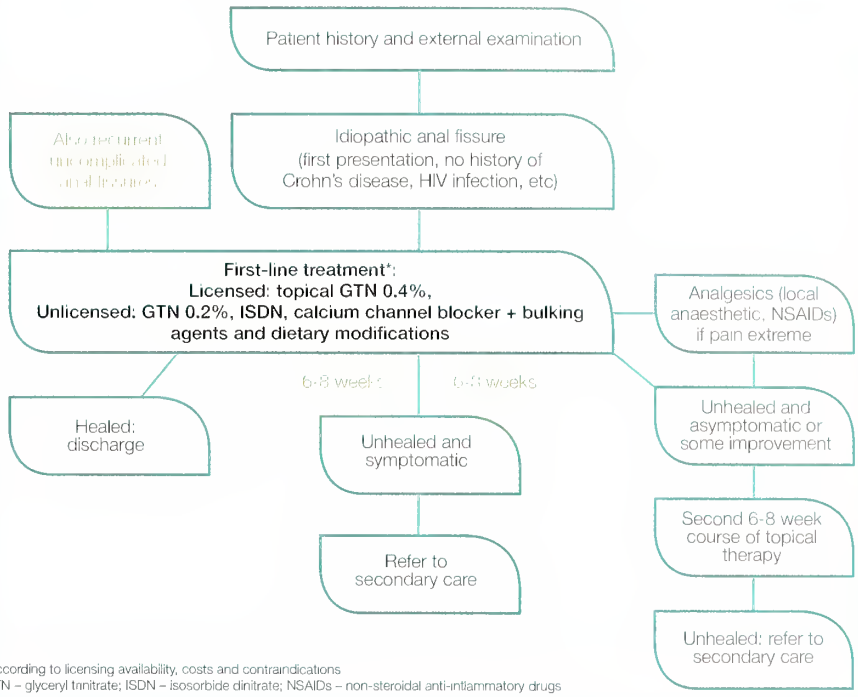
### What causes anal fissure?

The main causes of anal fissure are:

- passing a large or hard stool when constipated[2]
- bouts of diarrhoea[2]
- injury to the anal area during childbirth[3]
- habitual use of laxatives.[3]

## Primary care management of chronic anal fissure

Adapted from and approved by: Lund JN et al. An evidence-based treatment algorithm for anal fissure. *Tech Coloproctol* 2006; **10**: 176–179.




*according to licensing availability, costs and contraindications
GTN – glyceryl trinitrate; ISDN – isosorbide dinitrate; NSAIDs – non-steroidal anti-inflammatory drugs

Patients may present in the pharmacy environment asking for over-the-counter preparations believing they have piles or haemorrhoids, or because they feel too embarrassed to visit their GP. Although this is a sensitive and embarrassing issue to discuss, it is important to ask questions to establish more information about the problem. You can then reassure patients that there is treatment available and their GP can provide this for them.

Where appropriate offer patients lifestyle advice, suggest dietary modifications and ways of dealing with the discomfort. Patients should be advised that if their symptoms do not improve they should see their GP who will be able to prescribe a suitable treatment.

### Treatment options for chronic anal fissure in primary care

The treatment algorithm suggests a path of treatment for patients with chronic anal fissure pain.

In primary care, the patient is assessed and a full history is taken. On diagnosis of anal fissure the first-line treatment is with a topical medication to relax the internal anal sphincter muscle, together with bulking agents and advice on dietary modifications. Analgesics may also be prescribed if the patient is suffering extreme pain.[1]

*Glyceryl trinitrate (GTN)*

GTN has been used for decades in the treatment of angina. GTN taken sublingually (under the tongue) or orally relieves angina by relaxing the muscle surrounding the coronary arteries, enlarging the artery and increasing the blood supply to the heart. By a similar mechanism, GTN ointment alleviates fissure pain by relaxing the muscles of the anal sphincter and by improving the supply of blood to the site of the fissure.

Unlicensed GTN has also been compounded extemporaneously by local pharmacists at the request of physicians at a 0.2% concentration. As a result, there has been no standardised dose and there was the potential for inconsistent quality, supply and dosing. There is now a licensed 4mg/g (0.4%) GTN available for the treatment of chronic anal fissure pain. The use of the treatment algorithm and licensed product should standardise the treatment for patients with chronic anal fissures.

*Calcium channel blockers*

Nifedipine and diltiazem are potential alternative topical treatments to GTN,[3] although they remain unlicensed and are recommended for secondary care.

Urgent referral is required if the patient presents with symptoms and signs suggestive of colorectal or anal cancer.[3]

### Lifestyle advice[3]

Constipation can be helped by:

- *a high fibre diet with plenty of fluids*. This is the important part of treatment and prevention and means eating more fruit, vegetables, cereals, wholemeal bread etc and drinking at least 8 glasses of fluids a day
- *fibre supplements* are an option if a high fibre diet does not help with constipation
- *bulk-forming laxatives* such as methylcellulose may help treat constipation if the patient cannot achieve a high fibre diet (available via their GP).

### Dealing with the discomfort[3]

- *warm baths* – these can have a soothing effect and may help healing
- *anaesthetic creams or ointments* – these may help to ease pain, but the patient should not use them for more than 5–7 days as they may irritate the skin around the anus
- *hydrocortisone* – this could help reduce inflammation around the fissure and ease pain. In general, the patient should be advised not to use the ointment for more than 7 days
- *lubricants* – when these are used before passing a bowel movement they may help ease the associated pain
- *good toilet hygiene* – the patient should be encouraged to keep the anal area clean and dry
- *painkillers such as paracetamol* – should be considered to help with the pain
- *GTN* – for chronic anal fissures, it relaxes the muscles and tone around the anus. Advise the patient to insert the ointment into the anus for up to 8 weeks.

### References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3. Prodigy Guidance. Anal Fissure. Available at: www.prodigy.nhs.uk/anal-fissure/view_whole_guidance (date accessed: 22 September 2008).

# Results help direct arthritis treatment

Etoricoxib and diclofenac carry similar cardiovascular risks but have different rates of other side effects that should be used to direct treatment decisions, say US researchers.

Results from the multinational etoricoxib and diclofenac arthritis long-term trial (MEDAL) of 34,700 patients showed the increased rates of thrombotic cardiovascular events were similar for the two painkillers at 1.24 and 1.30, respectively, per 100 patient years.

However, rates of upper gastrointestinal clinical events such as perforation or bleeding were 31 per cent lower with etoricoxib than with diclofenac.

Rates of complicated upper GI events were similar between the two drugs.

Patients were randomised to 60mg or 90mg etoricoxib or 150mg diclofenac daily for an average of 18 months.

More patients discontinued use of etoricoxib because of swollen ankles and high blood pressure but diclofenac had higher rates of discontinuation due to adverse GI and liver events.

Both drugs were similarly effective.

"In clinical practice, the choice of anti-inflammatory agent needs to take into consideration the risk for thrombotic cardiovascular and gastrointestinal events as well as congestive heart failure and other renovascular effects," said lead investigator Christopher Cannon, of Harvard Medical School.

"[These results] will hopefully encourage guideline committees to continue developing recommendations for optimum treatment of patients with arthritis."

**For more information:**
Lancet, online publication, November 13, 2006

# Lifestyle counselling can reduce risk of diabetes

Lifestyle intervention in people at high-risk for type 2 diabetes does have a long-term effect on reducing diabetes risk, say Finnish researchers.

Initial results from the Finnish Diabetes Prevention Study reported in 2001 (New England Journal of Medicine) showed that intensive counselling on diet and exercise reduced the risk of diabetes by 58 per cent in overweight men and women with impaired glucose tolerance.

The 'active counselling' was continued throughout the four-year study, but now the researchers say that the reduced risk is sustained after counselling is stopped.

A further three years of follow-up in participants who had not already developed diabetes showed that lifestyle changes were being maintained.

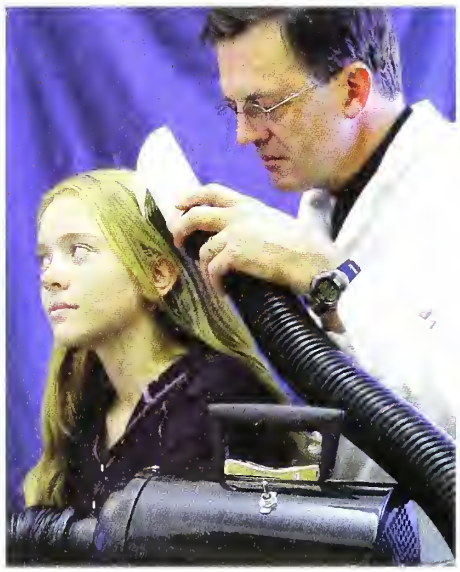
The reduced risk of developing diabetes after counselling ended was smaller but still significant at 36 per cent.

Over the full study period, participants in the intervention group had a 43 per cent lower risk of developing diabetes.

"Our study with a median of seven years total follow-up shows that marked differences in the cumulative incidence of diabetes can be sustained after the discontinuation of active counselling," said study leader Jaana Lindstrom (National Public Health Institute, Helsinki, Finland).

Active counselling in the study included detailed and individualised advice to achieve weight loss, decreased intake of fat and saturated fat, increased fibre intake, and moderately intense physical activity of 30 minutes per day or more.

**For more information:**
Lancet 2006; 368: 1673-79



# Chemical-free louse treatment uses hot air stream

University of Utah biologists have developed a chemical-free hot air device for eradicating head lice.

Results of a study of 169 infested children published in the November issue of Pediatrics showed that the Lousebuster prototype was effective after a single 30-minute treatment.

The air stream is not as hot as a standard hairdryer, and the inventors are anxious that parents should not attempt the treatment using a normal hairdryer as this will cause burning.

# Study results support Nice decision on inhaled insulin

Researchers responsible for a meta-analysis appear to support recent Nice guidance on the use of inhaled insulin.

Analysis of 16 randomised trials of 4,023 individuals with type 1 or 2 diabetes showed inhaled insulin is effective in lowering HbA1c and is more acceptable to patients.

There was no increased risk compared with subcutaneous insulin, but severe hypoglycaemia was three times more likely to occur with inhaled insulin than with oral agents.

Lack of long-term safety data led the US researchers to conclude that although inhaled insulin is an acceptable alternative to subcutaneous insulin, it should be reserved for those who are 'opposed to injections' and may not be controlling their condition as a result.

**For more information:**
Annals of Internal Medicine 2006; 145: 665-75

# Call for wider use of statins

Statins are cost-effective in a wider proportion of the population than is currently recommended, a new analysis of data from the Heart Protection Study shows.

Researchers at the University of Oxford worked out that 40mg of generic simvastatin is cost-effective in most age and risk categories looked at in the study, including those between 35 and 85 years and patients with an annual risk of a major vascular event as low as 1 per cent.

The team concluded that at current prices generic simvastatin 40mg daily would cost less than £2,500 per life year gained for people with an annual risk of major vascular events of 1 per cent or more, independently of age at start of treatment.

**For more information:**
British Medical Journal, online publication, November 10, 2006-11-09

# Erdostein for cough in COPD launched

An erdostein treatment for productive cough in exacerbations associated with COPD has been launched by Galen.

The first new mucolytic to be launched in the UK for over 25 years, erdostein is said to have anti-adhesive and antioxidant as well as mucolytic properties. It has been shown in studies to reduce cough severity and frequency when used in combination with amoxicillin compared with amoxicillin alone.

# SMC approves rituximab

The Scottish Medicines Consortium has announced that rituximab in combination with methotrexate can be prescribed by specialist physicians.

It should be used in adults with severe active rheumatoid arthritis who do not respond to anti-TNF therapies. Some 30 per cent of patients with severe RA fall into these groups.

**For more information:**
http://www.scottishmedicines.org.uk

## In brief

**Galderma** has withdrawn the 30g Silkis pack and the 30g Differin cream and gel packs. Silkis 100g and Differin 45g cream and gel packs remain available.

**Probiotics** are beneficial despite reports of sepsis in some patients, say researchers. A review of the literature has shown the benefits of probiotics outweigh any potential dangers. BMJ 2006; 333: 1006-08.

**Bonefos** 400mg x 30 caps and 800mg x 10 tabs have been withdrawn by Schering Health Care. The 400mg x 120 caps and 800mg x 60 tabs sizes remain available.

**The SMPC for Actos** (pioglitazone) has changed in line with the revised licence indication including triple therapy in combination with metformin and sulphonylurea.

**Zamadol** Melt 50mg 100 tablet pack is no longer available in the UK from Meda Pharma. Zamadol Melt 50mg 60 pack will continue to be available.

**Atrogel** Arnical gel is the first product to be granted registration by the MHRA under the EU Directive on traditional herbal products.

# ConfiDent future for denture care


ConfiDent is a new denture care range available from Wockhardt. On shelf now are denture cleansing tablets and denture fixative cream.

Coming soon, says Wockhardt, are a denture care brush, denture bath and a trial/travel pack comprising eight denture cleansing tablets, a 10ml tube of denture fixative cream, denture care brush, mint breath freshening strips and a denture care leaflet.

Point of sale materials including a merchandising unit for counter-top or shelf use and a promotional leaflet and dispenser will be available.

Wockhardt plans to enhance the range next year with the aim of establishing ConfiDent as the denture wearer's brand of choice.

**Price:** tablets 79p/30, 248-9128; fixative cream £2.79/40g, 228-9569

**Product info:**
Wockhardt UK Ltd
Tel: 01978 661261
enquiries@wockhardt.co.uk

# Bisodol adds that little bit extra

Bisodol Extra for relief from indigestion and heartburn has been launched by Forest Laboratories. The triple action fruit-flavoured tablets combine two antacids and a reflux suppressant: magaldrate, sodium bicarbonate and alginic acid.

Supporting the launch, a £1 million campaign will see TV ads running on Channel 4, Channel 5 and satellite from this week until January 7. Planned PR activity includes a series of radio interviews with dietician Nigel Denby, along with a consumer and trade media relations campaign. For pharmacies, a range of educational and point of sale materials is available.


**Price: £2.59/20**
**Pip code:** 325-1444

**Product info:**
Forest Laboratories
Tel: 01322 550550

# Carnation steps out for winter


The Carnation Footcare brand is continuing to benefit from a £500,000 advertising and PR exercise. National press ads have been running in, for example, the health sections of the Daily Mail and Daily Express, focusing on Corn Caps. The emphasis is now switching to other variants with ads in women's interest and the retirement press.

To help meet consumers' winter footcare needs, the brand offers Carnation Tip Toes to help customers with sore feet associated with high heeled shoes, Corn Caps, Bunion Pads, Blister care and Antifungal Footwipes. Pharmacists can benefit from a set profit margin of at least 33.3 per cent, says Carnation. There is a range of new display stands.

**Product info:**
Ceuta Healthcare
Tel: 0800 018 7117
www.carnationfootcare.co.uk

# Pucker up with ChapStick

Lip balm brand ChapStick has been given a make-over in preparation for the winter season.

Acting on the results of consumer research, manufacturer Wyeth has developed new formulations that offer benefits including SPF15, vitamin E, camphor and improved moisturisation. An Apple flavour has been launched and the Flava Craze range features three new flavours: Watermelon Splash, Tropical Twist and Apple Burst.

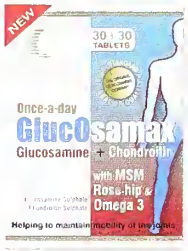
An updated ChapStick logo and redesigned packaging, said to be inspired by a healthy smile, give the brand a fresh, modern feel, says Wyeth.

**Price: from 99p**

**Product info:**
Wyeth Consumer Healthcare
Tel: 01628 669011

C+D BRAND FOCUS

## GlucOsamax Extra from Health Perception




Health Perception, the leading glucosamine specialist, has launched a new maximum strength joint care product crammed with the best ingredients to help maintain healthy joints.

New **GlucOsamax Extra** is a dual tablet formulation designed to provide complete nutritional support for your joints in a convenient once-a-day combination. It provides an innovative high strength combination of five key ingredients:

- **MSM** (Sulphur) is necessary for making collagen, the primary constituent of cartilage & connective tissue; it also enhances tissue pliability and promotes blood-flow, aiding the recovery process after physical activity.
- **Rose Hips** are rich in Vitamins A, C and E and cartenoids including beta-carotene, Lycopene and Lutein. They also contain flavanoids and beneficial fatty acids, which can help with the regeneration of the soft tissues.
- **Omega 3** can help to nourish and lubricate the joints, as well as providing EPA and DHA which are the nutrients used by the body to build cell structures and strengthen cell membranes.
- **Glucosamine Sulphate** helps to maintain joint mobility. It is a naturally occurring biochemical constituent found in healthy joint tissues. Structures such as cartilage, tendons and ligaments rely on this to provide support to promote continuous re-building.
- **Chondroitin Sulphate** is known as the 'liquid magnet' because it helps to attract fluid and nutrients into the joint.

**Tablet 1** providing MSM – 500mg, Rose-hip – 500mg, Omega 3 – 200mg.

**Tablet 2** provides Glucosamine – 665mg 2KCl (providing 500mg sulphate), Chondroitin – 400mg (90% marine source).

GlucOsamax Extra retails at £19.99 (for 30 + 30 tablets) and is available from major wholesalers or direct from Health Perception on **01252 861454** or **www.health-perception.co.uk**.

## Martindale™ Specials

We produce the following dosage formats in-house:

- Ampoules
- Capsules
- Creams and gels
- Eye drops
- Ointments
- Pessaries
- Powders
- Solutions
- Suppositories
- Suspensions

## Your first choice in Specials

At Martindale™ Specials your patients' needs are paramount at every stage of the order process. From how we take your order, to manufacturing it to our consistently high standards and through to final despatch, our total adherence to quality assurance and control ensures we get it right.

We provide world class service by investing in our facilities and our people

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Freefax 0800 393360
martindale-specials@cardinal.com

# Nomad cabinet from Surgichem

The Nomad trolley cabinet, which has been designed for use in care homes, is the latest addition to Surgichem's product range.

The trolley cabinet is robust, easy to manoeuvre and can hold up to nine standard blister racks or 60 Nomad cassettes, says Surgichem. The trolley has easy to clean shelves, providing ample storage for items such as bottles and creams, adds the company. The top has a non-slip work surface and a wall clamp is supplied.

The trolley cabinet claims to be a cost effective solution to transporting medication in the care home.

**Product info:**
Surgichem
Tel: 0161 406 8710

# Nytol's dream campaign

Sleep aid Nytol is set to benefit from a £1.5 million marketing spend spanning the next six months.

TV advertising began this week and continues until Christmas. The 20-second 'Dreamland' execution tells viewers how Nytol aids refreshing sleep and ends with the familiar strapline "Good mornings follow a good Nytol".

National press advertising is to begin on Monday and will run until early March.

Women aged 35 to 55 are being targeted via titles including Marie-Claire, Red, New Woman, Sunday Times Magazine and Independent on Sunday Magazine.


**Product info:**
GlaxoSmithKline Consumer Healthcare
Tel: 0845 762 6637



# Baby boon for kids' charities


Two children's charities are set to benefit from sales of Numark's own label baby wipes. The NSPCC and, in Scotland, Children 1st will get 10p from each sale of twin packs of the wipes featuring promotional outer packaging. The promotion will run until the 100,000 special packs run out, says the virtual chain, raising more than £10,000 in the process.

Helen Groves, Numark brand controller, comments: "With the Children in Need appeal taking place during the same month [as the promotion], children's charities are likely to be front of mind for customers and encourage them to choose our special edition NSPCC range over other brands."

**Product info:**
Numark
Tel: 01827 841200

## Products advertised on TV next week

Sponsored by Benylin


**Ambi Pur:** All areas & Sat except Ulster
**Aquafresh Base:** All areas & Sat except U, CTV, & GMTV
**Aquafresh Extreme:** All areas & Sat except U, CTV, & GMTV
**Bassetts Soft & Chewy Omega 3:** GMTV, Sat
**Beechams All in One:** All areas & Sat except U, CTV, & GMTV
**Benylin:** All areas & Sat except GMTV
**Bisodol:** C4, five & Sat
**Buttercup:** All areas & Sat except C4, five
**Covonia:** five, GMTV & Sat
**Cura-Heat Arthritis Pain Knee:** C4, five
**Cura-Heat Back & Shoulder Pain:** C4, five
**Cura-Heat Arthritis Pain Wrist:** C4, five
**DulcoEase:** GMTV
**New Gaviscon Double Action:** All areas & Sat
**Horlicks:** All areas except U, CTV & GMTV
**Just For Men:** All areas & Sat
**Night Nurse:** All areas & Sat except U, CTV & GMTV
**Nytol:** All areas & Sat except U & CTV
**Sensodyne Base:** Sat
**Sensodyne Pronamel:** Sat
**Seven Seas Cod Liver Oil:** All areas
**TENA Lady Mini Magic & TENA pants:** All areas
**Vicks Sinex Decongestant Capsules:** All areas & Sat
**Vicks First Defence Nasal Spray:** All areas & Sat
**Vicks First Defence Protective Hand Foam:** All areas & Sat
**Windsetlers:** five, GMTV only
**Ymea:** All areas & Sat except C4, five
**Zovirax:** All areas & Sat except U, CTV & GMTV
**PharmaSite for next week: Zovirax –** Windows, **Meltus –** In-store, **Pepto Bismol –** Dispensary
**Pharmacy channel: Anadin Ultra Double Strength, Eucerin, Dulcolax, British Dental Health Foundation (for Mouth Cancer Awareness week)**

A-Anglia, B-Border, C-Central, C4-Channel 4, five-Channel 5, CAR-Carlton, CTV-Channel Islands, G-Granada, GMTV-Breakfast Television, GTV-Grampian, HTV-Wales & West, LWT-London Weekend, M-Meridian, Sat-Satellite, STV-Scotland (central), TT-Tyne Tees, U-Ulster, W-Westcountry, Y-Yorkshire

# The pre-reg predicament

**Taking a pre-registration student can help your professional development, business, and your relationships with other healthcare professionals. Plus you'll get that warm glow... and you might help to avert a potential recruitment crisis**

**Jennifer Rigby**

It has not been a good few months for pharmacy graduates, what with the news that there are more students than ever competing for pre-registration places and that their ambitions – for the majority, owning their own pharmacy – are quite dramatically mismatched with reality.

In fact, the problems are so severe that some people believe that soon pharmacy students might face studying for four or five years to get their degree but then not be able to find a pre-registration place – meaning that they would not be able to register as practising pharmacists with the Royal Pharmaceutical Society.

Graham Phillips, chair of the Society's education committee, says: "There are enough approved training sites for the time being, although there is never a guarantee that any given site will take a trainee in any given year. The Society's major education policy development programme 'Fit for the Future' is currently underway and aims to look at all aspects of educating and training the pharmacy team of tomorrow." (C+D, November 18, p11).

Graham Phillips: There are no guarantees for trainees

Dr David Scott, a regional clinical training pharmacist who recruits all the students for hospital pharmacy placements in England and Wales, conducted a study to find out the scale of the problem. He says it's even worse than people think. "I am very worried about the big mismatch between the number of pharmacy graduates and the number of pre-registration places, and this is only going to get worse," he says. In 2006, in England and Wales, there were 1,625 pharmacy graduates. By 2007, there will be 2,152, and by 2010 there will be approximately 2,543, he says.

"The number of pre-registration places offered by the big employers – the multiples in community pharmacy and the hospitals – remain fairly constant," Dr Scott explains. "So the burden falls on the independent community pharmacy sector to absorb these increases, but we don't know if they will be able to do this when faced with such large increases. There are a lot of independent community pharmacists who would be eligible to take on a pre-registration student – but the question is whether they are willing."

Mark Donaghy runs the pre-registration programme at Waremoss Pharmacy Group, a chain of 28 pharmacies in Sussex, and he thinks pharmacists are willing, but need support. His role as professional development manager involves guiding pharmacists through the recruitment process. "Often our pharmacists come to us and say they would like to take a pre-registration student. They know it can be hard, but it can also be very rewarding," he says.

That all sounds very promising, but with reasonably sized chains such as Waremoss, which owns 28 pharmacies but is offering only 10 places, and similar sized chains such as Independent Pharmacy Care Centres (which owns 33) only offering five – and even with larger groups such as Alliance Boots only offering pre-reg places in a third of its pharmacies – can demand be met?

> There needs to be a more structured scheme to cope with demand – you don't want people to train for nothing

Lou Baxter, who is the head of professional development at IPC Centres, hopes so. "We are very concerned about the problems with pre-reg places. It's a worry for the whole profession. Where we can offer more places in the future we will try to," she says. "I think there needs to be a more structured scheme to cope with the demand – you don't want people to train for four or five years and then... nothing!"

Ms Baxter is keen to point out that, while IPC Centres does only take five pre-reg students, this is quite a leap considering it is only its third year of taking students at all. For the first two years the company only took one student. Waremoss has increased its intake too, and Kirit Patel, chief executive of Day Lewis, confirmed: "We are actively encouraging our managers to take on pre-regs – it's likely that we will double the number of ▶

See the future for pharmacy on page 11

A pre-registration student is for life, not just for Christmas. Are you prepared to make the commitment?

placements available next year."

So the companies are getting on board; but are the pharmacists themselves willing to get involved? And if not, what is putting them off?

Well, it shouldn't be a financial worry at least, experts have said. "There is a generous training allowance for community pharmacists," explains Dr Scott. In England and Wales the grant has recently been increased from around £6,500 to £16,440 per annum, in Scotland the grant is about £12,000 and in Northern Ireland around £6,000 per annum. The money can then be used to contribute to the student's salary, although it is up to the individual pharmacist as to what they pay, depending on factors such as demand.

The NPA pre-registration service found that the typical basic student salary in 2006 was in the range of £12,500 to £16,600. According to Alliance Boots's head of professional resourcing, Paul Stretton, some companies, such as Alliance Boots, offer the pharmacist additional financial incentives in recognition of the effort put in by the tutor.

Getting your pharmacy set up to take a student doesn't require you to jump through too many hoops either. "The regulations aren't arduous," Mr Donaghy adds. "First the pharmacy premises needs to be approved as a training premises by the Society, then the pharmacist needs to do the Society's training, which comes with the manual the Society will send them when they express an interest. Then they are ready, basically."

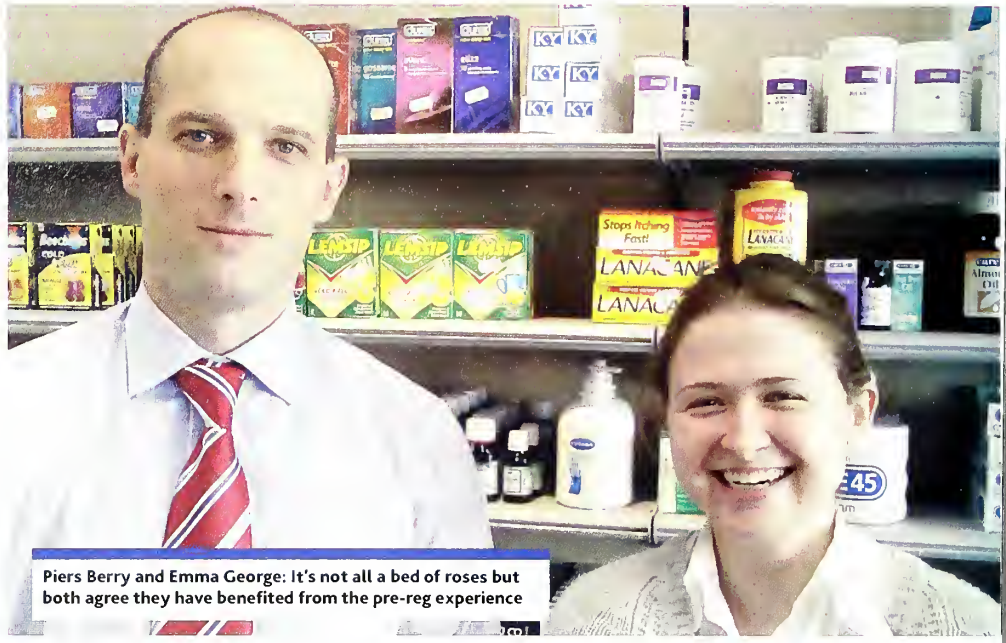
However, there is the possibly daunting issue of actually finding yourself a student once you have completed the registration requirements. While there are a lot of students out there, some pharmacists, particularly independents, are unsure of how to recruit them. Raj Nutan, business development manager at the NPA, helps run the year-old recruitment site – www.pharmalife.co.uk – which was set up to deal with this problem. "We found out that while a lot of independents were willing to take a pre-registration student, they didn't know how to get one – but now hopefully our site will show them the way," he explains.

"It's not exactly a dating service, but it is similar," he says. "The pharmacist places their vacancy on the site then students send their CVs in to us. We process them internally and send them out to the pharmacists. We get over 250 hits a week from students."

Independent pharmacies do also get students calling them out of the blue, and can forge strong links with local pharmacy schools to get students. You can even put posters in your window – but Mr Nutan says the most important thing is to get in there early if you want to be able to pick and choose your candidate. Large multiple chains, including Alliance Boots and Lloydspharmacy, have huge recruitment drives and Lloyds has already recruited 200 pre-regs for 2007.

Once you get a pre-reg student, you will find plenty of avenues to explore for support and training. All the multiples offer training and support for their pre-registration tutors – as well as for the tutees. "Before our pre-registration trainee arrives in our pharmacy, our tutors attend a workshop that covers every aspect of pre-registration training," says Alliance Boots's Mr Stretton. Numark also offers support to tutors through seminars for tutees, which ease the teaching burden on independent pharmacists. Even smaller groups such as Waremoss provide training days for both tutors and tutees, and the NPA also runs support courses and training days for pre-registration tutors and tutees for independents. The British Pharmacy Students Association is also happy to support the tutees throughout the year.

While taking a pre-registration student is a big commitment, testimonials from happy tutors and happy tutees are very convincing. "The practical benefits can be enormous," says Piers Berry, a first time tutor who runs the RJ Williamson pharmacy in Peacehaven. "I've learnt as much from Emma as she's learnt from me. It's certainly kept me on my toes – she'll ask me a question and I might not know and have to look it up, so it's a training




Piers Berry and Emma George: It's not all a bed of roses but both agree they have benefited from the pre-reg experience

## Raj Nutan's five key reasons to take a pre-reg

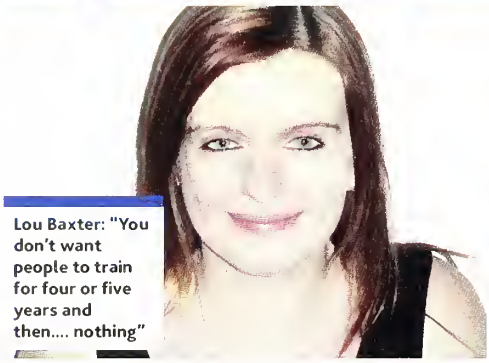
- A fresh pair of eyes to give new insight into your pharmacy.
- Another person to help train other staff members.
- Potential for the student to take on a special project, such as an audit.
- You could get a new pharmacist for your business at the end of the year who already knows the ropes.
- Professional satisfaction – not only are you helping others but you can really learn from your pre-reg student too.

Raj Nutan from the NPA is involved with its pre-reg 'dating service' which brings pharmacists and pre-regs together

Eager students look on at a training group provided by Numark

## NPA checklist – recruitment of a pre-registration student

1. Produce internal business case on recruiting a pre-registration student.
2. Check you fulfil the requirements for employing a pre-registration student – premises accreditation and pre-registration tutor requirements.
3. Ensure you work out the overall package for your prospective student including holidays etc.
4. Start your recruitment process early.



Lou Baxter: "You don't want people to train for four or five years and then.... nothing"

All the multiples offer training and support for their pre-registration tutors – as well as for the tutees

pdate for me. Or she asks the question, I tell her o look it up and she tells me the answer," he says.

"In some ways it has helped our relationship vith other health professionals too – she does a lay with the district nurses and a day with the GPs o now they come and chat to us because there's a ine of communication. So it's helped us, helped hem and probably helped the patients," he adds.

Ms Baxter from IPC Centres was a tutor for everal years before her current role. "I've been a utor and I know how rewarding it can be. It is vorthwhile for the pharmacist and for the harmacy team – at the end of the day the pre-reg an get involved with training the rest of the staff s well as learning from the technicians."

In fact, not one of the tutors C+D spoke to said hey'd had a negative experience – and neither did heir pre-registration students. Emma George, who vorks at Piers Berry's pharmacy in Peacehaven, ays that while it's a big shock to the system after eing a student, she's enjoying the learning xperience. "It's so different to just learning the heory," she says. "I think it's really important to earn about patients. Of course it's draining but it's o worth it for us."

Ai Nee Ng works at Hughes Pharmacy, which is owned by the IPC Centres Group. She's back, after 10 years working as a pharmacist in her home country of Malaysia, to do her pre-reg year in England, where she also completed her initial pharmacy degree in 1997. "It's all so different," she admits. "The support of a pre-registration tutor is really valuable. The best thing is learning how to put my knowledge into practice."

Amy Lepiorz is the vice-president of the BPSA, and now manages a branch of Lloydspharmacy. She did her pre-reg last year with Boots, and thinks that her experience landed her the job. "It was a very management orientated pre-reg year, which helped me get this job, and as it is a well known company everyone knows what standard to expect."

Of course, it's not all a bed of roses: Mr Berry admits that it is hard work to sit down with Emma and discuss all the things she needs to know – but at the same time he believes any pharmacy will almost certainly benefit from taking on a pre-registration student. And you'll get to go to pharmacy heaven for it, for sure. Mr Donaghy says that in his experience of pre-registration schemes he has only come across one occasion when the relationship didn't work.

"To be honest, the student wants it to work out, the pharmacist is glad to have the help, so the year tends to be a big success," he adds.

As well as the glow you get from helping your student, and helping the profession as a whole by making sure new pharmacists keep coming through the ranks, you may find that taking a pre-reg allows you to hand pick and personally train eager young pharmacists to take your business forward. As Ms Baxter says: "We wanted to put something back by offering training to pharmacists of the future, but at the same time we wanted to get our hands on some of our future pharmacists!"

### Information sources

- Check out the Royal Pharmaceutical Society website to find out how to become a tutor: www.rpsgb.co.uk
- Go to the National Pharmacy Association site, www.npa.co.uk, for more info and www.pharmalife.co.uk to use its pre-reg service
- For tutors in Scotland, up-to-date facts about the service can be found at www.nes.scot.nhs.uk/pharmacy, and tutors in Northern Ireland should go to www.psni.org.uk

# THE CONSULTATION ROOM AND THE ROLE

By Graham Phillips,
Community Pharmacist


The new pharmacy contracts, with their emphasis on promoting "wellness" and public health, have identified a number of areas in which pharmacists can make a real impact on the health of the communities they serve. Smoking is the single greatest cause of preventable illness and early death[1] so it comes as no surprise that pharmacists are increasingly encouraged to provide smoking cessation services.[2] These are commissioned as an Enhanced Service under the contract in England and Wales.

A successful smoking cessation service will be a valuable asset to your pharmacy and a major contributor to public health.

Smoking cessation services are funded and commissioned in England and Wales by local Primary Care Trusts (PCTs) to reflect local needs. Indeed, smoking cessation is high on the PCT commissioning agenda.[3] Since 2003, commissioning of smoking cessation services has increased by 30 per cent,[4] and a 2006 survey of all PCTs revealed that 77 per cent of those who responded have commissioned this service.[5]

## Financial considerations

A consultation room where you can discuss smoking cessation with your customers is an investment for your pharmacy because it is also a prerequisite for providing Advanced Services such as medicines use reviews. By providing further services, you can better utilise the consultation room and gain an additional return on the capital expenditure required to provide the room in the first place.

Some of the ongoing costs for a smoking cessation service may be funded by your PCT.[6] For example, carbon monoxide (CO) monitors may be supplied free of charge to your pharmacy and you may be reimbursed the cost of supplying treatment such as nicotine replacement therapy (NRT).[7] Your PCT may also provide a framework for the administration and audit of the new system.[7]

The main up-front cost, as with any new service, is locum cover (backfill) during staff training. Once the service is established, the real cost is the pharmacist and staff time required to provide the smoking cessation service (where the endpoint is usually a four week quitter). This needs to be adequately remunerated. As a rule of thumb, it costs approximately £1 per minute to run a pharmacy. For a more detailed business plan, the Pharmaceutical Services Negotiating Committee has produced a costing toolkit for Enhanced Services (see **www.psnc.org.uk** for more details).

## What are the requirements for staff training?

In order to qualify to provide an enhanced smoking cessation service from your pharmacy, your staff will need to be suitably trained to deliver a service that aims to provide individual support and advice. Your PCT may also have requirements for the training and accreditation of those pharmacists and assistants involved in the service.[7]

Almost 80 per cent of current community pharmacy-based smoking cessation services commissioned by PCTs agreed to undertake training and 60 per cent were subject to locally agreed accreditation.[8] The Health Development Agency has recommended that pharmacists and pharmacy assistants attend training that covers:[9]

- smoking demographics
- the effects of smoking and of stopping smoking
- smoking cessation treatments and their outcomes
- assessment
- pharmacotherapy
- behavioural support
- treatment programme
- monitoring and continuing education.

## The consultation room

Pharmacies offering a smoking cessation service must provide a consultation room that allows privacy between the pharmacist and customer. There are a number of considerations that need to be taken into account when planning a consultation room to ensure that it meets the requirements of the new contract (see Box 1).

## How to attract customers to your smoking cessation service

Although the PCT is responsible for promoting the service to the local population,[7] there are a number of specific initiatives that your pharmacy can pursue to attract clients:

- Make NRT products clearly visible. Not only will this increase sales but it will also draw attention to the smoking cessation service you offer.
- Promote key dates such as No Smoking Day – the next No Smoking Day is Wednesday, March 14, 2007.
- Inform local health care professionals and NHS Direct of your service so that they can refer patients to you.

You can also attract customers by identifying people who

BOX 1 CONSULTATION ROOM – PLANNING POINTS

- The room should be clearly designated and distinct from the general pharmacy shopfloor
- There needs to be enough space for two people to sit down comfortably
- The room should be accessible to disabled customers
- The room should be situated or designed so that a normal conversation cannot be overheard by other customers or staff
- There should be adequate space for leaflets, support materials and CO monitoring equipment

smoke and would like to stop (see Box 2). Prescriptions for conditions linked to smoking, and people presenting with minor ailments such as a cough, all provide opportunities to discuss smoking. Staff can be trained to ask customers buying a cough medicine whether they smoke. If they get a positive response they can let the customer know that the pharmacy can help them when they are ready to quit.

The next step is to determine whether the customer is motivated to quit.[1] If they are ready and would like to receive the pharmacotherapy and support offered through your service, you can arrange a consultation. A 'Simple steps' pathway has been developed, which outlines approaches that can be used by pharmacists to engage customers in a quit attempt.

**BOX 2 HOW TO IDENTIFY A MOTIVATED QUITTER**

To make the best use of your time, it is important to identify customers who are genuinely motivated to stop smoking. This can be done by asking three simple questions:

- Do you smoke?
- Would you like to stop smoking?
- Your best chance of quitting is with the help of experts trained to provide you with treatments and support to help you quit. Would you like this kind of help?

## In the consultation room – making a difference in smoking cessation

During the first consultation, you should assess your customer's willpower to quit, and then plan the quit attempt and agree a quit date. Ensure your customer knows what to expect and is aware that they need to work out how to deal with withdrawal symptoms and the temptation to smoke. There are resources available that may help you understand what your customer is experiencing (see Box 3). It is important to explain how pharmacotherapy can help reduce withdrawal symptoms and increase the chances of a successful quit attempt.

A meta-analysis has shown that NRT doubles the chances of a successful quit attempt,[2] while estimated figures suggest that NRT plus appropriate behavioural support make the chances of successfully quitting six times greater.[10] We are achieving 50 per cent four-week quit rates through the smoking cessation service we provide in our pharmacy. This is just as good as a specialist service would achieve.

Pharmacists should explain to smokers that, when they light up, it is the nicotine that gives them the hit and it is the rest of the smoke that can cause cancer.[11] It is vital that customers are educated about the comparative safety of NRT compared with continuing smoking, and the proven effectiveness of NRT in helping people to quit successfully.[12] Reassure your customer that although NRT replaces approximately 50 per cent of the nicotine they get from cigarettes, it doesn't deliver the harmful chemicals and gases that can lead to smoking-related diseases.[11,13]

In my experience, it is worthwhile introducing the CO monitor at this point in order to show your customer the dangerous levels of CO in their breath. This is a key motivational aid[1], particularly so if you explain how the quitter will see their CO level drop within the first week of quitting. Provisions for ongoing support and monitoring should be discussed with the customer before the end of their first consultation. You should also record any pharmacotherapy provided on the customer's pharmacy medication record, informing the patient's GP as appropriate.[1]

Follow-up sessions give vital support to quitters. NHS stop smoking services generally provide weekly appointments for up to four weeks after the quit date[1]. It is important to prevent relapse, and a measure that can help with this is to ensure that your customer takes the complete course of pharmacotherapy (eg 12 weeks of NRT) rather than stopping when they feel more able to cope with the withdrawal symptoms. It is important to help your customers to plan ahead for times when they may feel tempted to smoke, eg when out with friends, or at the pub when alcohol can lower inhibitions.

## Conclusion

Setting up a smoking cessation service requires investment, mainly of time and effort, from your pharmacy. In order to meet the current and future demands of the pharmacy contract as it evolves, it is crucial to re-engineer the pharmacy and provide an accredited consultation room. Providing a smoking cessation service will assist in recouping the capital cost of your investment, and there is the potential to receive significant support from your PCT, as well as helping to significantly improve public health in the community you serve.





**BOX 3: INTERNET RESOURCES FOR SMOKERS SEEKING TO QUIT**

A number of resources are available that can provide support to smokers and pharmacists.

www.ash.org.uk
www.click2quit.com
www.givingupsmoking.co.uk
www.globalink.org
www.quit.org.uk
www.treattobacco.net

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14. McRobbie H. *[illegible] to help [illegible]* London: Health [illegible]

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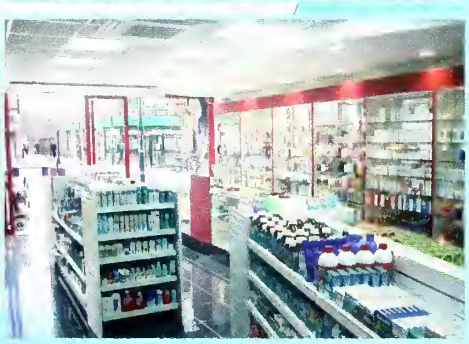

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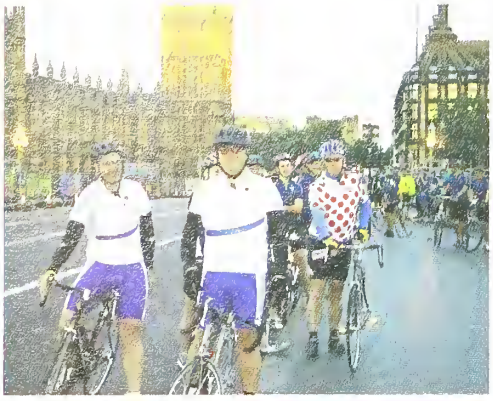
# Rowlands riders raise £50,000 for children's charity

## Great Ormond Street reaps rewards of sponsored bike ride



**The sixth annual Rowlands London to Paris** charity bike ride raised £50,000 for Great Ormond Street Children's Hospital.

Sixty one cyclists, including teams from parent group Phoenix, Numark and suppliers, completed the 200 miles with one or two minor injuries, the odd collision and a spell of bad weather.

"Perhaps the biggest challenge we faced was cycling around the Arc de Triomphe," said Mike Johnson, Rowlands' marketing manager.

"It's bad enough driving through the centre of Paris in a car, but when you're on two wheels it can be a real eye-opener. It called for some well planned defensive riding tactics, but we all made it unscathed."

Although Mr Johnson has completed the ride four times, arriving at the Eiffel Tower at the end is always very emotional. "The sense of achievement has to be experienced to make you understand how we feel," he said.

Mr Johnson also highlighted the importance of the cause and said they could not have completed the ride and raised so much money for Great Ormond Street without the help and support of sponsors and suppliers.


**From the left are: Nicole Cooke (champion cyclist), Raj Aggarwal, (vice-chairman, Kidney Wales), Catherine Stanley (CPW), Carwen Wynne-Howells, holding sporran, (chief pharmaceutical officer of Wales), Hemant Patel (RPSGB president), Peter Haydn Jones (CPW chief executive) and Umesh Patel (NPA chairman)**

# Celtic celebration of pharmacy unity

**One of the more unusual items for auction at** the gala dinner organised by Community Pharmacy Wales – to promote the success of pharmacy and friends in Wales working together – was the sporran of Scotland's chief pharmaceutical officer, Bill Scott.

Mr Scott said he was extremely pleased to support his Celtic colleagues and donate his sporran, bidding for which raised £1,000 for the charity Kidney Wales. Kirit Patel, chief executive of Day Lewis, fought off two other bidders to emerge victorious.

## Locum pharmacist pens winning line to snap up digital camera

A locum pharmacist from Preston in Lancashire has won a Nikon Coolpix S9 digital camera in a caption competition.

Raymond Lee penned the winning slogan in a competition run by Mandeville Medicines at last month's Pharmacy Show held at Birmingham's NEC. There were 150 entries.

In response to 'Long life specials are better than 28 days because…', Mr Lee answered '…Your patient's life is worth more than 28 days.'

Mr Lee has been employed as a locum pharmacist around the Blackpool area since the beginning of this year after spending 19 years with Boots, where he was a group pharmacy manager.

# From traffic warden to superhero

**Pharmacology drives the plot of 'Special', an** offbeat dark comedy released this week.

The film follows the journey of Les Franken, played by Michael Rapaport, a lonely traffic warden who decides to take part in a clinical trial for a new antidepressant called Special and ends up convinced that he is a superhero.

While his doctor dismisses the drug's side effect as an adverse psychological reaction to the medication, Les takes his cue from the comics he reads and embraces his new-found powers, quitting his job and devoting his life to fighting crime and protecting the world from the forces of evil.

Apparently the fictitious drug, Specioprin Hydrochloride, "inhibits the chemical in the brain responsible for self-doubt" and as a result, Les believes he has the ability to levitate, read people's minds and even walk through walls.

The film was inspired by the realisation that Batman, Spiderman, Superman and all the other great superheroes could just as easily be normal people suffering from psychotic delusions.

# Hello Dubai

**Sandra Waudby, who works mainly in the shop** at Weldricks in Brinsworth, Rotherham, will be jetting off to Dubai next year after winning September's Pharmacy Travel competition, which appeared in C+D's sister title, Pharmacy Today.

"I suppose I'll have to take my husband, Stephen," joked Ms Waudby. "We hope to go in November next year as we've already booked our summer holiday."

Ms Waudy has been working at Weldricks for 18 months and is about to start an NVQ3 management course. In her spare time she enjoys caravanning and chasing after her grandchildren William, aged four months, and Elizabeth, two.

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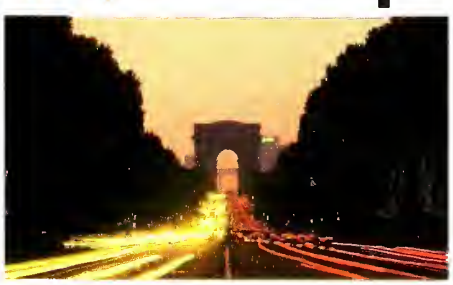

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